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LTC Melvin E. Leggett, Jr., MS

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AN ASSESSMENT OF PARTNERSHIP PROGRAM SUPPORT COSTS AT BROOKE ARMY MEDICAL CENTER

A Graduate Management Project

Submitted to the Faculty of

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In Partial Fulfillment of the

Requirements for the Degree

of

Master of Health Administration

by

Lieutenant Colonel Melvin E. Leggett Jr., MS

December, 1991

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Abstract

The costs of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) have dramatically increased in recent years, exceeding the annual growth rate of both national and military health care expenditures. Accordingly, CHAMPUS has become a primary target of Department of Defense (DoD) efforts to contain costs within the Military Health Services System.

The Military-Civilian Health Services Partnership Program is one method Military Treatment Facility (MTF) Commanders have at their disposal to contain the rapid increase in CHAMPUS costs experienced since the 1980's. Based on the premise that military health care is more economic than its civilian counterpart, the program is designed to recapture CHAMPUS workload by augmenting the MTF staff with civilian providers paid by CHAMPUS at a discounted rate.

There is considerable concern regarding the ability of the Partnership Program to realize its charge of cost effectiveness. Recent government studies indicate that the Partnership Program may increase government costs by encouraging greater utilization of services.

This study used Medical Expense and Performance Reporting System (MEPRS) data to determine the costs of supporting selected Partnership Agreements implemented at Brooke Army Medical Center (BAMC) and compared those costs to CHAMPUS costs within the BAMC catchment area. The standard MEPRS expense assignment system was modified to create a cost allocation model which more accurately reflected the administrative and ancillary support expenses likely to be common to both the military and civilian outpatient treatment settings.

This study provides an assessment of the ancillary and support costs associated with BAMC Partnership Agreements by clinical specialty. The study also suggests an appropriate cost allocation model to be used in the accurate determination of Partnership costs.

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Introduction

The development of cost effective health delivery systems is an emerging priority for governmental agencies, healthcare providers, and patients. Within the Department of Defense, the Civilian Health and Medical Program of the Uniformed Services has become a primary target of efforts to improve military health benefits and contain costs in the Military Health Services System (MHSS) (U.S. DoD, Review, 1989).

CHAMPUS is particularly fertile ground for cost containment efforts. The CHAMPUS inflationary rate, which is nearly three times its direct care counterpart, has doubled CHAMPUS costs in five years. Total CHAMPUS costs increased an average of 15.8 percent per year from 1983 to 1987. Direct care expenses, or the cost of providing health care to patients seen in military treatment facilities, rose only 5.8 percent per year during a similar period. (U.S. DoD, Review, 1989)

The greatest inflationary rate is found in that portion of CHAMPUS over which hospital commanders have the least direct control, outpatient care. From 1985 through 1987, CHAMPUS outpatient costs increased an average of 30.4 percent per year

compared to an annual increase of 11.8 percent in direct care outpatient costs (U.S. DoD, Review, 1989).

During the same period, inpatient CHAMPUS costs increased at an annual rate of 13.6 percent while annual increases in direct care inpatient costs were 6.1 percent (U.S. DoD, Review, 1989). The disparity between increasing costs in the direct care and CHAMPUS components of the MHSS prompted health care planners to develop strategies to contain the cost of CHAMPUS.

MHSS reform strategies have focused on several methodologies designed to improve patient access, insure quality, and contain the costs of CHAMPUS. The Military-Civilian Health Services Partnership Program (Partnership Program) was the focus of this study.

Military-Civilian Health Services Partnership Program

The Partnership Program was established under the provisions of Department of Defense Instruction (DoDI) 6010.12, dated 22 October 1987. As a component of Project Restore, the Partnership Program was conceived as one method of recapturing CHAMPUS workload by moving it back into the MTF. The Partnership Program, whose roots lay in the Joint Health Benefits Delivery

Program (JHBDP) of 1983, was designed as a means of containing the rapid increase in costs of CHAMPUS experienced during the 1980's (Lewin, 1989).

The purpose of the Partnership Program is threefold. First, it provides Military Treatment Facility (MTF) commanders one method of compensating for selected staff shortages, thereby improving the availability of health care to beneficiaries within the catchment area. Stated succinctly, the program is intended to improve patient access to care. Second, the Partnership Program is designed to meet the CHAMPUS demand in a manner more cost effective than standard CHAMPUS. Finally, the Partnership Program is intended to contain or reduce CHAMPUS expenditures (Hodges, 1990).

The Partnership Program is designed to integrate specific health care resources of the Uniformed Services with that of providers in the civilian health care community. It allows CHAMPUS beneficiaries access to inpatient and outpatient services from civilian providers working in MTF's and from military providers working in civilian facilities. The care is paid through CHAMPUS funds.

The Partnership Program provides MTF commanders the authority to negotiate agreements with civilian providers for the provision of CHAMPUS services on a discounted or fee schedule basis (Lewin, 1989). These discounts should be considerably less than the CHAMPUS allowable rates. The incentive for the civilian provider to engage in a Partnership Agreement is increased patient volume and lower administrative costs.

Under the provisions of the Partnership Program, agreements may be either internal or external. Internal agreements are for CHAMPUS authorized services rendered in the MTF by a CHAMPUS authorized provider. With the exception of some maternity and surgical care, internal Partnership services may not be provided in a setting other than an MTF.

Conversely, external Partnership agreements are for services performed by a military provider in a civilian facility. The military provider cannot be reimbursed by CHAMPUS. Both internal and external agreements afford MTF commanders the opportunity to expand the level of military health care by tapping into civilian resources at a discounted rate.

The Partnership Program is potentially advantageous to all participants. The patient benefits financially from the elimination of the standard co-payment and deductible. Patient access to care is also improved. The Partnership provider gains access to guaranteed patient volume and lower ancillary and support costs. Civilian hospitals, involved in external agreements, profit through increased patient volume. Military hospitals benefit from increased patient access, improved utilization, increased workload, reduced waiting times and a more satisfied beneficiary population (Hodges, 1990).

While the Partnership Program offers many potential benefits, there are a number of associated pitfalls as well. Ironically, the most serious of these is increased costs. The Program's two primary objectives, containing costs and improving patient access to care, can and do conflict. The volume of patients seeking care in the Partnership Program often increases as access improves. The patient population who would normally forego elective care under standard CHAMPUS, because of its additional cost and inconvenience, often seek treatment via the Partnership Program. This increase in the patient load, sometimes referred to as the

"ghost" population, can increase CHAMPUS expenditures in a catchment area.

Other potential Partnership problems include: (1) the tendency for MTF commanders to implement agreements with minimal regard to the cost containment issue since CHAMPUS pays the bills; (2) Partnership support costs borne by the MTF are not accurately calculated; (3) Partnership providers can earn substantially more than military providers engaged in the same care; (4) poor accountability of Partnership workload; and (5) poorly negotiated Partnership discounts based on state-wide prevailing rates rather than the provider's usual and customary rate (Hodges, 1990). This study focused on the second problem, the inaccurate calculation of Partnership Support costs.

A government study of the Partnership Program concludes that "the preliminary CHAMPUS workload and cost data imply an increase in total government cost due to greater utilization of services" (Lewin, 1989). Hospital commanders must carefully analyze any existent or potential use of the Partnership Program to determine if its use will satisfy the program's stated objectives.

Statement of the Problem

The problem is that CHAMPUS costs are too high and continue to escalate despite efforts at containment.

Literature Review

Cost containment is the major issue facing the U.S. health care industry today. Our health care system which "leads the world in technical sophistication and innovation" and "sets the standards of excellence that are emulated around the world," provokes nearly universal dissatisfaction at home (Relman, 1987).

> Americans believe that the United States is in a medical care cost crisis....The patient, who can rarely afford the expense of high-technology care out-of-pocket, serves in an advisory capacity, ultimately receiving the care that his insurer decides is worth the expense. (McCue, 1989)

Indeed, cost containment is among the most contentious issues facing health care planners today. It is an issue which evokes considerable passion because it exposes the great contradictions of the U.S. health care system. It forces health care leaders and policy makers to face "the paradox of excess and deprivation" (Enthoven & Kronick, 1989).

National Health Care Expenditures

National expenditures for health care services increased an average annual rate of 10.4 percent during the 35 year period from

1950 to 1985 (Renn, 1987). The U.S. currently spends approximately 11.5 percent of the Gross National Product (GNP) on health care and is projected to increase that amount to 15 percent by the year 2000 (Enthoven & Kronick, 1989).

In 1988, $541 billion were spent on health care in the United States, or roughly $2000 for every person (Coile, 1990). The U.S. Department of Commerce estimates that health care expenditures will top $756 billion in 1991 (Health, 1991). By the turn of the century, health care will consume $1.5 trillion or $5,551 per person (National Leadership Commission, 1989).

In comparison, the Canadian health care system costs 25 percent less than its American counterpart. The U.S. spends 300 percent more per capita for health services than the United Kingdom (Cyphert & Rohrer, 1988).

There are a number of factors driving the increase in national health care costs, including: general price inflation; medical care-specific inflation; population growth; the aging population; expanding technology; changing utilization patterns; and "defensive medicine" (U.S. DoD, Review, 1989). Interestingly, the Health Care Financing Administration (HCFA) attributes only a

small portion of the increase in health care expenditures to population growth and changes in age and sex characteristics.

The primary causes of increasing medical expenditures are thought to be medical-specific and economy-wide inflation. Economy-wide inflation accounted for 39 percent and medical-specific inflation 18 percent of the increase in health care costs between 1983 and 1987 (U.S. DoD, Review, 1989).

Military Health Care Expenditures

Expenditures within the MHSS have also grown rapidly and now represent nearly five percent of the total DoD budget. The rate of increase in CHAMPUS costs has outpaced the growth of national health care expenditures with total CHAMPUS costs increasing an average of 15.8 percent per year from 1983 to 1987 (U.S. DoD, Review, 1989).

The dramatic increases in CHAMPUS workload and costs have made annual DoD budget supplements almost routine. CHAMPUS business has grown from 650,000 claims and $70 million in fiscal year 1966 to greater than 10.5 million claims and $2.6 billion in fiscal year 1988 (U.S. DoD, Review, 1989). That

dollar amount represents nearly 20 percent of the total DoD health care expenditures (U.S. GAO, 1990).

While increases in national health care expenditures are thought to be primarily the result of inflationary pressures, cost and utilization increases in the MHSS are associated with the changing demographics of the non-uniformed military beneficiary population. This group of beneficiaries has grown almost 40 percent from 4.5 million in 1956 to 7 million in 1989 (U.S. DoD, Review, 1989).

The beneficiary population has not only grown substantially, it has also experienced a dramatic change in constitution. In 1956, the active duty force and its family members made up 90 percent of the nearly 6.5 million beneficiaries. Today this group accounts for little over half of all DoD beneficiaries. "The growth rate of retirees, their dependents, and survivors is a key factor to understanding cost and utilization increases in both the civilian and military components of the MHSS" (U.S. DoD, Review, 1989).

Changes in the active component are equally startling. Colonel Douglas A. Braendel, in his Senior Service College Fellowship Paper entitled "A Managed Care Model for the Military

Departments" summarized changing demographics within the DoD as follows:

> Probably the greatest change affecting health care delivery was the decision by our national leadership to adopt an all volunteer force. While the predominantly drafted armed forces were composed of mostly single men and women, the all volunteer force included a much larger number of family members, thereby significantly increasing total beneficiaries. (1990)

As the DoD non-uniformed beneficiary population has grown, military hospitals and clinics have been hard pressed to keep pace with the demand for health care services. The difficulty in meeting the demand for care in direct care facilities has increased the demand for CHAMPUS. This increased demand is reflected in a major workload shift from the direct care system to CHAMPUS (U.S. DoD, Review, 1989).

The outpatient direct care system treated 1.4 million fewer CHAMPUS eligible patients in fiscal year 1988 than in fiscal year 1985 (a 5 percent reduction). CHAMPUS paid for 3.4 million more visits in fiscal year 1988 than in fiscal 1985 (a 69 percent increase).

The story is similar on the inpatient side, where the direct care component admitted 12 percent fewer CHAMPUS eligible patients while CHAMPUS admissions claims were up 15 percent during the same period. (U.S. DoD, Review, 1989)

The workload shift is particularly evident among the family members of active duty. CHAMPUS admissions for this group increased an average of 7.5 percent annually between 1983 and 1987. Outpatient visits for active duty family members rose 19.5 percent annually. The shift in active duty family member workload is particularly troublesome because the government's CHAMPUS cost share is higher than would be the case with retirees and their family members. (U.S. DoD, Review, 1989)

The alarming shift in workload from the direct care side to CHAMPUS and its accompanying increase in costs prompted the implementation of Project Restore in fiscal year 1988. The three primary features of this program were: (1) the appropriation of CHAMPUS funds directly to the Services' Operations and Maintenance accounts; (2) the implementation of the Partnership Program allowing MTF commanders to supplement their staffing with CHAMPUS funded civilian health care clinicians; and (3) the

institution of Nonavailability Statement (NAS) goals to hold issuance to 1986 rates (Lewin, 1989).

The basic idea behind Project Restore is that health care provided in MTF's is generally less expensive than care provided under CHAMPUS. This premise is supported by a recent General Accounting Office (GAO) report which found that military hospital care would cost from 43 to 52 percent less than CHAMPUS-funded care (1990).

The Military Health Services System can not only provide health care for less, it also has the physical capacity to absorb a portion of the CHAMPUS workload. The GAO report also found that in fiscal year 1988 "military hospitals had an overall occupancy rate of 45 percent based on designed capacity. At the same time about 70 percent of the CHAMPUS costs were being incurred near military hospitals" (1990).

Partnership Program

The presence of both the financial incentive and the physical capacity to treat patients within the MHSS provide solid underpinning for the Military-Civilian Health Services Partnership Program. The Partnership Program implementing instructions

state that the purpose of the program is to make health care services "more available to health care beneficiaries using the Civilian Health and Medical Program of the Uniformed Services" and to integrate military and civilian health care resources to "improve the cost-effectiveness of the DoD health care delivery system" (U.S. DoDI, 1987).

The Partnership Program expanded and replaced the Joint Health Benefits Delivery Program (JHBPD) implemented in 1983. Although similar, the Partnership Program has a number of advantages over the JHBPD by:

- Eliminating the requirement for the beneficiary to pay the CHAMPUS deductible and co-payment if the care is provided in a military MTF (Internal Partnership Agreement).
- Providing authority for military providers to treat CHAMPUS eligible patients in civilian medical facilities (External Partnership Agreement) thus saving both the government and the patient their apportioned cost of civilian provider fees.
- Providing a simplified 30-day approval process for negotiated Partnership Agreements.

- Allowing for the payment of the costs of certain support personnel, equipment, and supplies furnished by the civilian provider when these resources are not otherwise available in the military MTF, provided the costs are included in the provider's allowable charges and the services are a CHAMPUS benefit.
- Permitting the MTF commander, as a provision of the Partnership Agreement, to use currently available supplemental care funds to provide for the treatment of noneligible CHAMPUS beneficiaries (i.e., active duty personnel, MEDICARE eligible family members or retirees, dependent parents, etc.) at negotiated rates. (Munley, 1988)

Guidance provided to MTF commanders emphasizes the need to carefully analyze all potential Partnership Agreements and, in particular, ensure that the use of the Partnership Program is "more economical to the Government than referring the need for health care services to the civilian community under the normal operation of the CHAMPUS program" (U.S. DoDI, 1987).

To assess the cost of Partnership, commanders are directed to make a comparison between CHAMPUS costs for a particular

health service in the community, both with and without the use of the Partnership Program. The comparison should take into account the extent to which the provider in the internal agreement will be supported by his own personnel and other resources under his direct control. In external agreements, the provider fees which would otherwise be applicable under regular CHAMPUS should be considered. (U.S. DoDI, 1987)

Commanders are told to require participating civilian health care providers, to the extent possible, to use MTF resources such as specialty consultants, ancillary services, equipment, and supplies. Additionally, the MTF should assist in providing appropriate administrative support as necessary to expedite the reimbursement of civilian providers.

Hospital commanders have made considerable use of the Partnership Program. Over 1400 agreements were in effect as of July 1990. However, there is considerable concern regarding the ability of the Partnership Program to realize its charge of "cost effectiveness in relation to standard CHAMPUS" (Mendez, 1990).

This concern has led policy makers to supplement Partnership Program guidance and the responsibilities of MTF commanders as follows:

- The Partnership cost analysis must take into account the impact on aggregate costs incurred by the government, including both changes in aggregate utilization as well as changes in unit costs.
- The Partnership cost analysis should take into account the type of care to be provided by the Partner when evaluating the cost effectiveness of agreements. This will include both situations where the Partner may place increased demands on MTF services and situations where the Partner may reduce CHAMPUS costs by bringing increased inpatient admissions to the MTF.
- Negotiated discounts should take into account the provider's actual billing history. If discounts are to be stated in terms of discounts off the state prevailing rates, the Partner's billing history should also be examined relative to the state prevailing rate.

- Negotiated discounts should also take into account any incremental increase in MTF costs for ancillary of administrative, support resulting from the Partnership agreement.
- MTF Commanders must monitor the impact of the Partnership program on MTF services to ascertain whether it has helped the MTF recapture CHAMPUS workload. (Newhall,1990)

Purpose

The purpose of this study was to determine the costs of supporting the Military-Civilian Health Services Partnership Program Agreements negotiated at Brooke Army Medical Center and compare them to analogous CHAMPUS costs within the catchment area.

Methods and Procedures

Data

The sample for this study was drawn from outpatient Partnership Agreements currently in effect at Brooke Army Medical Center, San Antonio, Texas. The average cost per visit of 13 Partnership agreements were compared to CHAMPUS costs in the BAMC catchment area as reflected in published CHAMPUS reports.

Data regarding the costs of Partnership Agreements in effect at BAMC were gathered from several sources, including written documents maintained in the Patient Administration and Resource Management Divisions. Data sources used included: formal Partnership Agreements; the Medical Expense and Performance Reporting System (MEPRS); and published CHAMPUS reports. MEPRS cost data were drawn from the period 1 October 1989 to 30 September 1990.

The reliability of MEPRS data suffers somewhat from inconsistent reporting. Workload and workhours are reported to the Resource Management Division by each workcenter in accordance with established guidelines. The interpretation of these

guidelines varies between workcenters and can lead to inaccurate reporting. The Resource Management Division does conduct regular assessments of data reporting and takes corrective action as necessary.

The study had two primary objectives: the first was to accurately determine the cost of supporting selected Partnership agreements at BAMC; the second objective was to compare the average cost of BAMC Partnership agreements to the CHAMPUS costs of outpatient care provided in the civilian community.

An accurate assessment of the cost of a given Partnership Agreement required a knowledge of the negotiated reimbursement rate and an accurate estimate of the cost of providing support to the Partnership physician. Information regarding the reimbursement rates of BAMC partners was gleaned from copies of the negotiated agreements. Additional costs of supporting the BAMC partnership program were measured through a retrospective analysis of information contained in the MEPRS.

MEPRS

MEPRS is a DoD direct care data base composed of three main elements: workload data, personnel utilization data, and expense

data. Workload data consisting of hospital admissions, occupied bed days, outpatient visits, weighted procedures, etc., are collected, in part, to justify manpower and budgetary requirements in each work area.

Accurate cost allocation of the salaries of assigned military and civilian personnel and the reporting of available man-hours are found within the Personnel Utilization data. Personnel costs are computed by the Medical Expense and Performance Module (MEPM). The MEPM produces salary cost and full-time equivalent (FTE) reports for each MEPR code by several criteria including: military; civilian; contract; volunteer; and personnel category (clinician, direct care professional, registered nurse, direct care paraprofessional, and administrative). (U.S. DoDI, MEPRS, 1986)

Expense data are collected from Accounting and Finance automated reports and other manually computed worksheets. All costs to operate the facility, including salaries, supplies, equipment, contractual services, travel, depreciation, and non-reimbursable support are used in computing total expenses. Workload, personnel utilization, and expense data are charged

against six basic functional areas: (1) inpatient care; (2) ambulatory care; (3) dental care; (4) ancillary services; (5) support services; and (6) special programs. (U.S. DoDI, MEPRS, 1986)

The final product of the MEPR is a unit cost to treat inpatients or outpatients by sub-specialty and a weighted formulation called a Medical Work Unit (MWU). MWU's are used for budgeting, cost comparison, and resource allocation within DoD.

An accurate assessment of BAMC partnership agreement costs is dependent on a clear understanding of the expense allocation (step-down) methodology used in MEPRS. In its Initial Report on the Cost-Effectiveness of the Partnership Program, Lewin/ICF commented that "careful consideration regarding the appropriate data necessary for a definitive determination of Partnership's cost-effectiveness is required (1989)." The report recommends that MTF's collect workload and expense data which accurately portray Partnership activity.

The Automated Source Data Collection (ASDC) System is the computer system designed to collect workload, personnel utilization, and expense data within MEPRS. The ASDC system uses several steps to distribute (stepdown) expenses from

supporting MEPR accounts to produce a report that reflects the cost of an occupied bed day, clinic visit, or other procedure. (U.S. DoDI, MEPRS, 1986)

The system first develops a matrix to apportion expenses from ancillary and support accounts to inpatient and ambulatory accounts based on workload. The amount distributed to each workcenter is based on specific criteria and proportional to the percentage of the total organization workload the workcenter represents. For example, the housekeeping expenses allocated to Ward A would be determined by the square feet cleaned compared to the total organizations's square feet cleaned.

The second step in the MEPRS stepdown process is the distribution of expenses. Expenses for Support accounts ("E" MEPR codes) are apportioned to inpatient, ambulatory, dental and ancillary accounts based on specific criteria including: occupied bed days; clinic visits; square feet; available FTE's; material issued; and rations served. Support accounts include items such as depreciation, logistical support, housekeeping, resource management support, and laundry services. In essence, support

accounts can be thought of as administrative support to workcenters. (U.S. DoDI, MEPRS, 1986)

Ancillary accounts ("D" MEPR codes) represent clinical support to workcenters and include pharmacy, laboratories, radiology, surgical suite support, and therapeutic functions. These accounts are distributed to inpatient, ambulatory, and dental accounts based on number of weighted procedures, minutes of service, or visits charged to the workcenter requesting the service.

The third step in the MEPRS stepdown process is purification. In this step, the expenses from inpatient and clinic "cost pools" are distributed to MEPR codes. A cost pool is defined as a workcenter which shares personnel, space, supplies, or other resources. Many inpatient wards are cost pools because patients with different MEPR codes occupy beds on the same ward. The expense of supporting ward functions represented by salaries, supply costs, and training costs are allocated to the MEPR codes of hospitalized patients. The same process is used to allocate ambulatory clinic expenses. (U.S. DoDI, MEPRS, 1986)

The workload factor used to prorate expenses in the inpatient setting is occupied beds; expenses are assigned based on

the percentage of occupied bed days of each MEPR code compared to the total occupied bed days on that ward. Clinic expenses are prorated based on the percentage of clinic visits by MEPR code compared with total visits to that clinic.

Although the MEPRS at BAMC assigns health care delivery expenses in accordance with the sophisticated matrix described, it does not automatically isolate and identify the cost of supporting Partnership physicians. This study used the proportion of workload accounted for by the Partnership physician to further allocate total Partnership expenses. This method identified specialty-specific ancillary ("D" account) and support ("E" account) expenses and assigned them to Partners based on their percentage of the workload.

Comparing CHAMPUS and MEPRS Data

One aspect of military health care that distinguishes it from its civilian counterpart is that ambulatory care is usually delivered in a hospital (MTF) setting while civilian outpatient care is often delivered outside the hospital. This distinction becomes particularly important when attempting to compare the costs of

ambulatory Partnership Agreements with their CHAMPUS counterparts.

CHAMPUS defines outpatient visits as medical care and treatment received by a patient from an authorized provider in the provider's office, in the home, in an outpatient department of a hospital or other authorized institution. Visits are limited to specifically designated procedure codes which exclude radiology, pathology, and laboratory procedures. The number of procedures for ancillary services such as radiology, pathology, and laboratory are referred to as "Non-Visit Services" in CHAMPUS reports. The total government cost of CHAMPUS outpatient visits and non-visit services by primary diagnosis in a given catchment area is provided in paragraph IV of the CHAMPUS Health Care Summary Report. (U.S. DoD, User's Guide, 1989)

It is important to note that CHAMPUS reports do not include pharmacy costs as a non-visit service. Nor are they included as a portion of the visit cost. Pharmacy costs are a separate report item referred to as "Costs for Outpatient Prescription Drugs." These costs are reported by beneficiary category, not by primary diagnosis. As a result, civilian pharmacy costs are not provided in

the analysis of CHAMPUS costs on a per-visit or by-specialty basis. This fact is especially crucial when attempting to compare CHAMPUS and MEPRS data.

Although CHAMPUS automatically excludes some ancillary support services (i.e. pharmacy) from the costs of outpatient visits, MEPRS does not. The MEPRS cost allocation matrix assigns ancillary support expenses to outpatient clinics based on clinic visits and other factors. A simple comparison of CHAMPUS outpatient professional services costs to a MEPRS based assessment of the cost of hospital based Partnership agreements may yield misleading results. The costs of the Partnership agreements may appear comparatively high since they often include ancillary costs not expressly included in the CHAMPUS outpatient figure. A more reasonable comparison may be achieved if CHAMPUS outpatient costs were compared to MEPRS data which, for the purposes of comparison only, exclude the allocation of pharmacy costs to outpatient clinics.

The allocation of administrative support costs to outpatient clinics may also result in Partnership cost comparisons which lead to specious conclusions. Since the provision of outpatient care at

BAMC is hospital based, total center administrative support costs are automatically and proportionately allocated against Partnership agreements by MEPRS. It is not clear, however, if the costs of administrative support to a tertiary level medical such as BAMC are reasonably comparable to the administrative support costs of a stand-alone ambulatory clinic. The potential to overstate the administrative costs of Partnership agreements may be offset by removing administrative costs peculiar to a medical center or activity such as Graduate Medical Education support, Health Facilities Project Office, and Special Staff from the expense assignment process. In this study, a model which reflects administrative support expenses which were likely to be common to both treatment settings including Ambulatory Administration, Housekeeping, Communications, and Lease of Real Property was created to allow for more appropriate comparison.

Study Design

Cost comparisons with CHAMPUS were made using three different expense assignment models. The first model was the one currently used by BAMC to estimate Partnership costs and is henceforth referred to as the Current Model. The Current Model

includes all "E" accounts (support) assigned against specific clinics and their Partnership physicians based on FTE's, outpatient visits, or square footage. This model partially includes "D" accounts (ancillary) reflecting some pathology costs. The Current Model does not include other "D" accounts, specifically pharmacy and radiology since, at BAMC, these costs are not automatically expensed to the Partnership level. The Current Model includes both fixed and variable costs (Tables 1-4). Please note that the abbreviations Current, V C, and Comp were used in Tables 1-4 to denote Current Model, Variable Cost Model, and Comparative Model respectively. In addition, MEPRS codes having no recorded value in a given model were inappropriate to that model and excluded from the table.

The second model includes only variable costs and is referred to as the Variable Cost Model. Variable costs are those costs that "change in a linear fashion with a change in volume" (Neuman, Suver, and Zelman, 1988). The Variable Cost Model was included in this study in an attempt to isolate those costs which were solely attributable to the advent of the Partnership Program. Interviews with the clinical and administrative department chiefs responsible

Table 1

Partnership Support Costs

by MEPR Code, Clinic, and Model

MEPR CODE	DESCRIPTION	Internal Medicine			Allergy			Neurology			Audiology		
		Current	V C	Comp	Current	V C	Comp	Current	V C	Comp	Current	V C	Comp
EABA	Depreciation	4,427		4,427	1,444		1,444	215		215	1,382		1,382
ECHA	Fire Protection	3			0			0			0		
ECIA	Police Protection	35			5			0			6		
ECKA	Other Base Support	408			177			15			191		
EDBA	Operation of Utilities	5			1			0			1		
EDDA	Minor Construction	164			22			0			28		
EDFA	Lease of Real Property	2			0			0			0		
EDJA	Communications	108			47			5			50		
EFBA	Housekeeping – Contract	668			90			0			113		
EBAA	Command	191			82			7			89		
EBAL	Facility Proj Office	8			3			0			4		
EBBA	Special Staff	420		420	184		184	16		16	197		197
EBBH	Health Promotion Pgm	69			30			2			33		
EBCA	Resource Management	243		243	106		106	9		9	114		114
EBCB	Mltary Persnnl & Admin	342			149			13			161		
EBCC	Committees	51			22			1			25		
EBCI	Information Management	567		567	247		247	21		21	265		265
EBDA	Clinical Management	2,295		2,295	1,001		1,001	85		85	1,075		1,075
EBEA	Graduate Medl Education	1,865			813			69			873		
EBFA	Educ & Traing Spt Pgm	678			296			25			317		
EBGA	Peacetime Exercises	3			1			0			0		
EDAA	Plant Management	55			7			0			9		
EEAA	Logistics	89			18			0			35		
EFAA	Housekeeping – In-house	71			10			0			12		
EGAA	Biomed Equipment Repair	0			10			0			0		
EHAA	Laundry Service	20			2			0			0		
EKAA	Ambulatory Care Admin	1,608		1,608	524		524	78		78	502		502
	Clinic Direct Cost	4,769	154	5,880	1,020	152	1,258	392	10	64	3,471	99	3,678
	Sub Total "ADMIN SUPPORT"	$19,164	$154	$15,440	$6,311	$152	$4,764	$953	$10	$488	$8,953	$99	$7,213
DAAA	Pharmacy	0	52,692	0	0	4,677	0	0	890	0	0	0	0
DBAA	Clinical Pathology	5,256	5,025	5,025	1,732	1,676	1,676	87	250	250	0	0	0
DCAA	Diagnostic Radiology	0	3,839	3,839	0	251	251	0	220	220	0	0	0
	Sub Total "ANCILLARY SUPPORT"	$5,256	$61,557	$8,864	$1,732	$6,603	$1,927	$87	$1,359	$469	$0	$0	$0
	TOTAL SUPPORT	$24,420	$61,711	$24,304	$8,043	$6,755	$6,691	$1,040	$1,369	$957	$8,953	$99	$7,213

Table 2

Partnership Support Costs

by MEPR Code, Clinic, and Model

MEPR CODE	DESCRIPTION	Pulmonary Current	Pulmonary V C	Pulmonary Comp	Rheumatology Current	Rheumatology V C	Rheumatology Comp	Ophthalmology Current	Ophthalmology V C	Ophthalmology Comp
EABA	Depreciation	264		264	770		770	3,293		3,293
ECHA	Fire Protection	0			0			4		
ECIA	Police Protection	1			3			47		
ECKA	Other Base Support	36			57			301		
EDBA	Operation of Utilities	0			0			7		
EDDA	Minor Construction	3			14			221		
EDFA	Lease of Real Property	0			0			3		
EDJA	Communications	10			16			80		
EFBA	Housekeeping – Contract	10			57			900		
EBAA	Command	17			28			141		
EBAL	Facility Proj Office	0			1			6		
EBBA	Special Staff	37		37	59		59	311		311
EBBH	Health Promotion Pgm	6			10			50		
EBCA	Resource Management	21		21	34		34	180		180
EBCB	Mltary Persnnl & Admin	31			49			252		
EBCC	Committees	4			7			38		
EBCI	Information Management	50		50	80		80	418		418
EBDA	Clinical Management	203		203	325		325	1,696		1,696
EBEA	Graduate Medl Education	165			265			1,378		
EBFA	Educ & Traing Spt Pgm	60			96			502		
EBGA	Peacetime Exercises	1			0			2		
EDAA	Plant Management	1			5			74		
EEAA	Logistics	14			21			412		
EFAA	Housekeeping – In-house	1			6			96		
EGAA	Biomed Equipment Repair	0			0			468		
EHAA	Laundry Service	0			0			50		
EKAA	Ambulatory Care Admin	96		96	280		280	1,196		1,196
	Clinic Direct Cost	379	79	406	1,530	117	1,636	11,280	2,463	13,557
Sub Total "ADMIN SUPPORT"		**$1,410**	**$79**	**$1,077**	**$3,713**	**$117**	**$3,184**	**$23,406**	**$2,463**	**$20,651**
DAAA	Pharmacy	0	914	0	0	4,270	0	0	4,584	0
DBAA	Clinical Pathology	705	312	312	1,125	894	894	3,866	3,746	3,746
DCAA	Diagnostic Radiology	0	0	0	0	756	756	0	578	578
Sub Total "ANCILLARY SUPPORT"		**$705**	**$1,226**	**$312**	**$1,125**	**$5,920**	**$1,650**	**$3,866**	**$8,908**	**$4,325**
	TOTAL SUPPORT	**$2,115**	**$1,305**	**$1,389**	**$4,838**	**$6,037**	**$4,834**	**$27,272**	**$11,371**	**$24,976**

Table 3

Partnership Support Costs

by MEPR Code, Clinic, and Model

MEPR CODE	DESCRIPTION	Otorhinolaryngology Current	V C	Comp	Gynecology Current	V C	Comp	Pediatric Current	V C	Comp
EABA	Depreciation	211		211	5,559		5,559	50,491		50,491
ECHA	Fire Protection	0			4			45		
ECIA	Police Protection	0			46			556		
ECKA	Other Base Support	15			684			3,024		
EDBA	Operation of Utilities	0			7			82		
EDDA	Minor Construction	0			217			2633		
EDFA	Lease of Real Property	0			3			33		
EDJA	Communications	4			181			799		
EFBA	Housekeeping – Contract	0			883			11606		
EBAA	Command	7			320			1,413		
EBAL	Facility Proj Office	0			13			57		
EBBA	Special Staff	16		16	705		705	3,115		3,115
EBBH	Health Promotion Pgm	3			116			510		
EBCA	Resource Management	9		9	409		409	1,808		1,808
EBCB	Mltary Persnnl & Admin	13			573			2,532		
EBCC	Committees	2			86			380		
EBCI	Information Management	21		21	949		949	4,194		4,194
EBDA	Clinical Management	89		89	3,848		3,848	17,009		17,009
EBEA	Graduate Medl Education	71			3,128			13,825		
EBFA	Educ & Traing Spt Pgm	26			1,137			5,028		
EBGA	Peacetime Exercises	0			4			14		
EDAA	Plant Management	0			72			876		
EEAA	Logistics	0			300			1923		
EFAA	Housekeeping – In-house	0			94			1143		
EGAA	Biomed Equipment Repair	0			190			420		
EHAA	Laundry Service	0			9			51		
EKAA	Ambulatory Care Admin	76		76	2,019		2,019	18,340		18,340
	Clinic Direct Cost	754	291	129	17,328	2,545	19,253	105,391	10,068	123,883
Sub Total "ADMIN SUPPORT"		$1,317	$291	$551	$38,884	$2,545	$32,742	$247,298	$10,068	$218,840
DAAA	Pharmacy	0	214	0	0	23,415	0	0	169,069	0
DBAA	Clinical Pathology	0	249	249	6,612	6,210	6,210	58,630	41,564	41,564
DCAA	Diagnostic Radiology	0	360	360	0	1,810	1,810	0	53,739	53,739
Sub Total "ANCILLARY SUPPORT"		$0	$823	$609	$6,612	$31,435	$8,020	$58,630	$264,372	$95,303
	TOTAL SUPPORT	$1,317	$1,114	$1,160	$45,496	$33,980	$40,762	$305,928	$274,440	$314,143

Table 4

Partnership Support Costs

by MEPR Code, Clinic, and Model

MEPR CODE	DESCRIPTION	Podiatry Current	Podiatry V C	Podiatry Comp	Psychiatry Current	Psychiatry V C	Psychiatry Comp	Optometry Current	Optometry V C	Optometry Comp
EABA	Depreciation	3,488		3,488	3,235		3,235	4,939		4,939
ECHA	Fire Protection	4			22			9		
ECIA	Police Protection	48			276			107		
ECKA	Other Base Support	441			716			729		
EDBA	Operation of Utilities	7			41			16		
EDDA	Minor Construction	227			1309			508		
EDFA	Lease of Real Property	3			17			6		
EDJA	Communications	117			189			193		
EFBA	Housekeeping - Contract	926			5330			2068		
EBAA	Command	206			335			341		
EBAL	Facility Proj Office	8			14			14		
EBBA	Special Staff	454		454	737		737	751		751
EBBH	Health Promotion Pgm	74			121			123		
EBCA	Resource Management	263		263	428		428	436		436
EBCB	Mltary Persnnl & Admin	369			599			610		
EBCC	Committees	56			91			94		
EBCI	Information Management	611		611	994		994	1,010		1,010
EBDA	Clinical Management	2,479		2,479	4,029		4,029	4,101		4,101
EBEA	Graduate Medl Education	2,015			3,274			3,334		
EBFA	Educ & Traing Spt Pgm	733			1,191			1,213		
EBGA	Peacetime Exercises	2			4			2		
EDAA	Plant Management	76			435			169		
EEAA	Logistics	33			63			267		
EFAA	Housekeeping - In-house	99			568			220		
EGAA	Biomed Equipment Repair	0			0			1050		
EHAA	Laundry Service	0			0			6		
EKAA	Ambulatory Care Admin	1,267		1,267	1,175		1,175	1,794		1,794
	Clinic Direct Cost	9,621		11,045	33,223	117	41,293	18,448	1,431	22,853
Sub Total "ADMIN SUPPORT"		$23,627	$0	$19,607	$58,416	$117	$51,891	$42,558	$1,431	$35,884
DAAA	Pharmacy	0	449	0	0	2,159	0	0	802	0
DBAA	Clinical Pathology	4,190	2,891	2,891	0	0	0	0	0	0
DCAA	Diagnostic Radiology	0	1,402	1,402	0	10	10	0	18	18
Sub Total "ANCILLARY SUPPORT"		$4,190	$4,742	$4,293	$0	$2,169	$10	$0	$820	$18
	TOTAL SUPPORT	$27,817	$4,742	$23,900	$58,416	$2,286	$51,901	$42,558	$2,251	$35,902

for implementation of the Partnership Program reveal that no additional personnel were hired nor any overtime used in support of the program. Additional equipment has not been purchased. The resulting components of the Variable Cost Model include all "D" accounts (radiology, pharmacy, pathology). All "E" accounts, with the major exception of supplies, were excluded from this model since they were considered to be fixed costs (Tables 1-4).

The third model used in this study was the Comparative Model (Tables 1-4). The Comparative Model includes both "E" and "D" accounts. Specific administrative costs, however, were removed from the assignment process. These costs, such as administrative support to Graduate Medical Education, are a legitimate expense of doing business at a tertiary level medical center, but are unlikely to be common to the average civilian ambulatory clinic. Such costs were deleted from the Comparative Model. Seven of the 27 "E" account items were included in this model as follows: (1) Depreciation; (2) Special Staff; (3) Resource Management; (4) Information Management; (5) Clinical Management; (6) Ambulatory Care Administration; and (7) Clinic Direct Costs (Appendix A). The selection of these particular

accounts was designed to provide a rough approximation of the expenses likely to be common to both treatment settings. Pharmacy costs were excluded from the "D" account costs because they are not included by primary diagnosis in the CHAMPUS Health Care Summary. The Comparative Model contains fixed and variable costs.

One final adjustment was made to the cost assignment process used by MEPRS. In the Current Model MEPRS allocates pathology support costs against the Partnership Physician based on his proportion of the total hospital workload. The researcher modified the formula in the Variable Cost and Comparative Models so that ancillary costs are allocated to Partnership Physicians based on their proportion of their clinic workload (Table 5).

This indirect measure of ancillary costs compared Partnership workload against the workload of the specialty in which Partners work and used the resulting proportion to estimate costs attributable to Partners. For example, measurement of the use of Pathology services by Partners in Internal Medicine was not unduly influenced by radically different rates of use by Partners in

Audiology. This allocation methodology provides specialty-specific information undiluted by hospital-wide comparisons.

Ethical Considerations

Since this research did not include the use of human subjects and data-gathering violated no rules of confidentiality, there was no breach of ethical precepts.

Results

The use of three alternative cost allocation models in conjunction with the modified expense assignment methodology provided considerably different estimates of the cost of supporting the Partnership Program. Since the expense assignment methodology used at BAMC does not automatically expense Pharmacy, Radiology, or clinic supply costs against Partnership Physicians, this study used a proxy measure of those costs by determining the Partnership proportion of clinic workload by clinical subspecialty (Table 5). These workload proportions were then multiplied by the Pharmacy, Radiology, and supply costs allocated to the clinic in which the Partners work. The resulting amount was used as an indirect measure of the Partnership portion of these ancillary and support accounts.

Partnership Workload Proportions

Pediatric Partners had the highest number of clinic visits, while Podiatry Partners displayed the highest proportion of total clinic workload. In 8 of 13 clinics, Partners accounted for less than 5 percent of the total workload. In 3 clinics, Partners accounted for less than 1 percent of the workload.

Table 5

Partnership Workload Proportions

CLINIC	TOTAL VISITS	PARTNERSHIP VISITS	PERCENT PARTNERSHIP
Podiatry	2,984	911	30.53
Pediatrics	44,045	13,187	29.94
Psychiatry	10,447	845	8.09
Optometry	19,893	1,290	6.48
Gynecology	24,294	1,452	5.98
Ophthalmology	22,625	860	3.80
Audiology	10,722	361	3.37
Rheumatology	6,883	201	2.92
Internal Medicine	54,754	1,156	2.11
Allergy	22,583	377	1.67
Neurology	10,532	56	.53
Otorhinolaryngology	12,476	55	.44
Pulmonary Disease	20,246	69	.34

Partnership Proportion of Supply and Ancillary Costs

Partners in the Department of Pediatrics demonstrated the highest supply costs while Podiatry, which had the highest

Partnership percentage of total clinic workload, had no supply costs allocated to Partners. The highest supply cost per visit was found in Otorhinolaryngology (Table 6).

Pediatric Partners had the highest total pharmacy costs while Audiology showed none. The highest pharmacy cost per visit belonged to Internal Medicine being more than twice as expensive as its nearest competitor, Rheumatology (Table 7).

Pediatric Partners claimed the highest total pathology costs while Psychiatry, Optometry, and Audiology showed no pathology costs. The highest per visit pathology costs were seen in Otorhinolaryngology (Table 8).

Partnership radiology costs were again highest in Pediatrics. Partners in Pulmonary Disease and Audiology showed no radiology costs. Otorhinolaryngology claimed the highest radiology costs per visit (Table 9).

In summary, aggregate costs for supply and all ancillary support to Partners were highest in Pediatrics. The per visit costs for supply, Pathology, and Radiology were highest among Partners in Otorhinolaryngology. Internal Medicine recorded the highest Pharmacy costs per visit.

TABLE 6

Partnership Supply Costs (Presented in Dollars)

CLINIC	TOTAL SUPPLY COSTS	PARTNERSHIP SUPPLY COSTS	PARTNERSHIP SUPPLY COST PER VISIT
Otorhinolaryngology	6,042	291	5.29
Ophthalmology	64,796	2,463	2.86
Gynecology	42,575	2,545	1.75
Pulmonary Disease	23,270	79	1.15
Optometry	22,070	1,431	1.11
Pediatrics	33,628	10,068	.76
Rheumatology	4,008	117	.58
Allergy	9,114	152	.40
Audiology	2,952	99	.27
Neurology	1,954	10	.18
Psychiatry	1,447	117	.14
Internal Medicine	7,272	154	.13
Podiatry	0	0	0
Summation (Σ)	279,128	17,526	
Mean			1.12
Std Deviation (σ)			1.48

Table 7

Partnership Proportion of Pharmacy Costs (Presented in Dollars)

CLINIC	TOTAL PHARMACY COSTS	PARTNERSHIP PHARMACY COSTS	PARTNERSHIP PHARMACY COSTS PER VISIT
Internal Medicine	2,495,778	52,692	45.58
Rheumatology	146,220	4,270	21.24
Gynecology	391,763	23,415	16.13
Neurology	167,302	890	15.89
Pulmonary Disease	268,079	914	13.25
Pediatrics	564,695	169,069	12.82
Allergy	280,149	46,677	12.41
Ophthalmology	120,591	4,584	5.83
Otorhinolaryngology	48,596	214	2.56
Psychiatry	26,694	2,159	2.56
Optometry	12,360	802	.62
Podiatry	1,471	449	.49
Audiology	0	0	0
Summation (Σ)	4,523,698	264,135	
Mean			11.55
Std Deviation (σ)			12.41

Table 8

Partnership Proportion of Pathology Costs (Presented in Dollars)

CLINIC	TOTAL PATHOLOGY COSTS	PARTNERSHIP PATHOLOGY COSTS	PARTNERSHIP PATHOLOGY COSTS PER VISIT
Otorhinolaryngology	56,372	249	4.53
Pulmonary Disease	91,655	312	4.52
Neurology	46,994	250	4.46
Allergy	100,372	1,676	4.45
Rheumatology	30,618	894	4.45
Ophthalmology	98,563	3,746	4.36
Internal Medicine	238,032	5,025	4.35
Gynecology	103,906	6,210	4.28
Podiatry	9,470	2,891	3.17
Pediatrics	138,824	41,564	3.15
Psychiatry	-0-	-0-	-0-
Optometry	-0-	-0-	-0-
Audiology	-0-	-0-	-0-
Summation (Σ)	914,806	62,817	
Mean			3.20
Std Deviation (σ)			1.89

Table 9

Partnership Proportion of Radiology Costs (Presented in Dollars)

CLINIC	TOTAL RADIOLOGY COSTS	PARTNERSHIP RADIOLOGY COSTS	PARTNERSHIP RADIOLOGY COSTS PER VISIT
Otorhinolaryngology	81,739	360	6.55
Pediatrics	179,491	53,739	4.08
Neurology	41,289	220	3.93
Rheumatology	25,878	756	3.76
Internal Medicine	181,829	3,839	3.32
Podiatry	4,592	1,402	1.54
Gynecology	30,281	1,810	1.25
Ophthalmology	15,207	578	.67
Allergy	15,035	251	.67
Psychiatry	127	10	.01
Optometry	280	18	.01
Audiology	-0-	-0-	-0-
Pulmonary Disease	-0-	-0-	-0-
Summation (Σ)	575,748	62,983	
Mean			1.98
Std Deviation (σ)			2.18

Partnership Program Total Support Costs

Estimates of the Partnership share of supply and ancillary support costs by clinical specialty were entered into the three cost models as appropriate. The resulting estimates of Partnership total support costs are contained in Table 10.

The Pediatric clinic had the highest total support costs in each of the three models. However, the per visit accounting of total support varied by model. The Current Model ranked Psychiatry Partnerships as number one in per visit support costs. Internal Medicine had the highest per visit cost in the Variable Cost Model and Psychiatry was again the highest cost per visit clinic in the Comparative Model.

The cost of supporting the Partnership Program at BAMC varies according to the clinical specialty, number of visits, and model. When Partnership support costs were ranked in descending order by clinic, 10 of the 13 specialties are equally positioned across at least 2 of the models. Only two of the specialties, Pediatrics and Gynecology, are ranked the same by all three models.

Table 10

Partnership Support Costs by Model (Presented in Dollars)

CLINIC	CURRENT MODEL	VARIABLE COST MODEL	COMPARATIVE MODEL
Internal Medicine	24,420	61,711	24,304
Allergy	8,043	6,755	6,691
Neurology	1,040	1,369	957
Audiology	8,953	99	7,213
Pulmonary Disease	2,115	1,305	1,389
Rheumatology	4,838	6,037	4,834
Ophthalmology	27,272	11,371	24,976
Otorhinolaryngology	1,317	1,114	1,160
Gynecology	45,496	33,980	40,762
Pediatrics	305,928	274,440	314,143
Podiatry	27,817	4,742	23,900
Psychiatry	58,416	2,286	51,901
Optometry	42,558	2,251	35,902
Summation (Σ)	558,213	407,460	538,132

Partnership Support Costs Per Visit

Additional insight into the costs of supporting BAMC Partnership physicians was gained through a thorough examination of the cost per visit data by model (Table 11). The Current Model, which consists predominately of fixed costs with some variable costs, lists Psychiatry, at $69.13 per visit, as the most expensive program to support. These high costs were ascribed almost entirely to fixed MEPRS costs (Table 9). In fact, Psychiatry had no ancillary cost allocations and only accounted for $.14 per visit in supply costs. The Variable Cost Model, consisting of variable costs only, depicted a radically different picture of clinic expense, ranking Internal Medicine the most expensive Partnership to support at $53.38 per visit. Almost all of these costs were attributed to ancillary support, in particular, pharmacy costs (Table 1). Not surprisingly, Internal Medicine demonstrated the highest pharmacy cost per visit (Table 7).

The Comparative Model, consisting of fixed and variable costs, showed Psychiatry to be the most expensive clinic to support.

Table 11

Partnership Support Costs per Visit by Model (Presented in Dollars)

CLINIC	CURRENT MODEL	VARIABLE COST MODEL	COMPARATIVE MODEL
Internal Medicine	21.12	53.38	21.02
Allergy	21.33	17.92	17.75
Neurology	18.57	24.45	17.08
Audiology	24.80	.27	19.98
Pulmonary Disease	30.65	18.91	20.13
Rheumatology	24.07	30.03	24.05
Ophthalmology	31.71	13.22	29.04
Otorhinolaryngology	23.95	20.25	21.09
Gynecology	31.33	23.40	28.07
Pediatrics	23.20	20.81	23.82
Podiatry	30.53	5.21	26.23
Psychiatry	69.13	2.71	61.42
Optometry	32.99	1.74	27.83
Mean	29.49	17.87	25.96
Std Deviation (σ)	12.82	14.38	11.36

Discussion

In March of 1991, BAMC conducted the Quarterly Partnership Cost Analysis for the period October through December 1990, in accordance with guidance provided by Headquarters, Air Training Command (Chong, 1990). The Outpatient Services Analysis portion of this report used CHAMPUS reimbursement information and MEPRS cost data to determine the average Partnership cost per visit at BAMC. The cost assignment methodology used to determine Partnership support costs was the same as the Current Model discussed in this study. The average Partnership cost per visit was then compared to the average government cost of CHAMPUS outpatient visits inside the BAMC catchment area.

CHAMPUS cost information for the Quarterly Analysis was based on 12 months of data (July 1989 through June 1990) drawn from the CHAMPUS Health Care Summary by Primary Diagnosis report. MEPRS cost data used in the Analysis spanned the same period used in this study: 1 October 1989 through 30 September 1990.

In the Quarterly Analysis, the average Partnership support cost per visit (referred to as MEPRS marginal cost in the report) was

estimated to be $27.66. After adding these support costs to the reimbursement rates contained in the Partnership Agreements, the author of the Analysis concluded that, compared to CHAMPUS, BAMC outpatient Partnership Agreements were losing, on average, $8.80 per visit, resulting in a total government loss of $56,724.80 for the quarter (Appendix B).

The results of this author's analysis of Partnership costs differ from those contained in the Quarterly Report. The mean Partnership support cost per visit obtained using the Current Model was $29.49. This result was unexpected, since the Current Model was designed to mimic the calculations used in the BAMC Quarterly Analysis. The most likely explanation for the difference between the Quarterly Analysis and the Current Model calculation of average support costs was the period of data (one quarter versus one year of data respectively). Substituting the Current Model estimate of support costs meant that BAMC was actually losing $10.63 per Partnership visit adding $11,832.78 to the losses reported for the quarter. Multiplying the $10.63 loss per visit by the total Partnership visits for Fiscal Year 1990 (20,820) resulted in

an annual estimated BAMC loss of $221,316.60 when compared to the cost of CHAMPUS.

The Variable Cost Model painted a much different picture of the financial status of the BAMC Partnership Program. The mean Partnership support cost per visit under this model was $17.87. This support cost was $9.79 less than the figure reported in the Quarterly Analysis and $11.62 less than the Current Model estimate. The difference in the support costs resulted in a $.99 gain per visit and annual gain of $20,611.80 when compared to catchment area CHAMPUS costs.

As expected, the Comparative Model yields results somewhere between the other models. With a mean Partnership support cost of $25.96 per visit, the Comparative Model is $1.70 less than the $27.66 estimated by the BAMC Quarterly Analysis and $3.53 less than the Current Model estimate. When compared to CHAMPUS, this model projects a loss of $7.10 for every Partnership visit, or $147,822 for Fiscal Year 1990.

This study's three models and the BAMC Quarterly Analysis demonstrated considerably different estimates of Partnership Program costs and savings (or losses). The Current Model was

most like the BAMC Analysis since it included the same elements of fixed and variable costs. These elements were comprised of some ancillary support costs (specifically Clinical Pathology) and all administrative support costs. Unlike the Current Model, the Variable Cost Model appropriately included all ancillary costs, because they were likely to increase incrementally as the total number of Partnership visits increased. The Comparative Model was similar to the Current Model including some administrative and ancillary support costs.

Of the three models, the Variable Cost Model provided the most accurate assessment of the cost of supporting the Partnership Program because it excluded total fixed costs. Total fixed costs were excluded because they do not vary with changes in patient volume.

The total cost of supporting BAMC Partnership Physicians is equal to the total fixed cost plus the total variable cost of providing support. As the number of patient visits increases, total fixed costs remain the same while per-visit fixed costs decrease. Conversely, the per-visit variable cost remains constant while total variable cost increases with increases in visits. As a result, the

total cost of supporting the Partnership Program increased only by the amount of the increase in the total variable cost (Neumann, Suver, and Zelman, 1988). Please note that this analysis did not include the payment Partnership physicians receive in the form of a specific percentage of CHAMPUS reimbursement since that amount is pre-set in the Partnership Agreement. Allocating fixed cost accounts against Partners in an effort to determine support costs merely credited the Partnership program with costs that would have been incurred whether or not the program existed.

The mean cost of Partnership support per visit was lowest in the Variable Cost Model despite the inclusion of all ancillary costs. However, the same model demonstrated the greatest range and variance among per visit support costs by clinical specialty (Table 11). Unlike the Current and Comparative Models, the Variable Cost model showed support costs were highest in Internal Medicine. Examination by MEPR code showed that increased support costs in that clinic were largely attributable to Pharmacy costs (Table 1). In contrast, the other two models showed support costs highest in Psychiatry (Table 11). Ironically, these costs were almost entirely fixed and reflected virtually no ancillary support costs.

Although the Variable Cost Model provided the most accurate accounting of the actual cost of supporting the Partnership Program, it was not entirely suitable for comparisons with CHAMPUS published data. CHAMPUS does not include an accounting of Pharmacy costs by clinical specialty, but rather, provides a lump sum amount by catchment area. Pharmacy costs, however, were an important determinant of the overall Partnership support costs of each clinic.

Conclusions

This research indicated that the BAMC Partnership Program was cost-effective when viewed from the perspective of average cost per visit. Using the Current Model, the sum of the average support costs ($29.49) plus the average negotiated reimbursement rates ($50.55) exceeded the average CHAMPUS allowable charges ($69.41) by $10.63 per visit, and led to the conclusion that the Partnership Program was cost-ineffective. Conversely, when Variable Cost Model support costs averaging $17.87 were added to the reimbursement rates, total Partnership costs were $.99 per visit less than the CHAMPUS allowable charge. This result suggests that the Program was, marginally, cost-effective.

As a point of comparison, the Partnership support cost per visit at Wilford Hall Air Force Medical Center for, the period October 1989 through June 1990, was $14.86 (Talking Paper). This figure is much more compatible with the support costs estimated by the Variable Cost Model.

Partnership Program managers should use a variable cost model when assessing the costs of supporting Partnership physicians. The Variable Cost Model produced substantially

different estimates of the cost of supporting the Partnership Program compared to the current model used by BAMC. These differences were brought about by the exclusion of fixed costs and the inclusion of all variable costs, particularly ancillary support costs. The Variable Cost Model identified marginal increases in support costs attributable to increases in patient volume.

One primary distinction between the research models and model currently used by BAMC was the attempt to determine Partnership support costs by clinical specialty. Current estimates of total BAMC Partnership costs were based on the reimbursement rate plus a facility-wide average support cost. The researcher believes that the use of facility-wide averages obscures useful management information and weakens the leadership's ability to make informed decisions regarding the Partnership Program.

The development of clinic-specific cost information provides decision-makers the opportunity to compare and contrast the relative costs of specific Partnership agreements. It also permits ready comparison to specific categories of care included in the CHAMPUS Health Care Summary Report.

Accurately measuring the cost of supporting the Partnership Program at BAMC was hampered by the absence of needed information. The MEPRS expense assignment methodology clearly influenced the validity of cost data. Much of the data provided by MEPRS was based on indirect measures which assigned costs in proportion to specific factors such as workload, FTE's, or square footage. The cost of doing business in Internal Medicine, for instance, was directly related to the number of patient visits but only indirectly related to patient acuity. Data regarding the cost of pharmaceuticals maintained on the BAMC formulary were readily available, but information identifying the cost of Pharmacy support to the Partnership Program was only available through proportional computation. The result was a dearth of information regarding the direct cost of supporting the Partnership Program.

The MEPRS data required to generate Partnership cost estimates were not readily accessible. All of the data used in this study were manually extracted from MEPRS reports. MEPRS had no ad hoc reporting capability which allowed automated access to Partnership related data.

Comparisons between Partnership Program and CHAMPUS costs found in this study and in the BAMC Quarterly Partnership Cost Analysis were made in accordance with guidance provided by Headquarters, Air Training Command. This guidance directs MTF's to compare the average Partnership cost per visit with the average government cost per visit as reported in the CHAMPUS Health Care Summary Report.

The Variable Cost Model used to estimate average Partnership costs included all ancillary support including Pharmacy costs. Pharmacy costs, however, are not included in the CHAMPUS average government cost per visit. Pharmacy costs are provided in the CHAMPUS Cost and Workload Regionalization Report where they are displayed as government costs for outpatient prescription drugs per patient per report period.

This research revealed that straightforward comparisons between Partnership costs and the average government costs reflected in the CHAMPUS Health Care Summary report are inappropriate. Partnership cost estimates which include ancillary support expenses (as they should) may appear artificially high in comparison to CHAMPUS costs which exclude Pharmacy costs per

visit. A valid comparison between the two programs will require access to data concerning the CHAMPUS per visit cost of Pharmacy.

Recommendations

This results of this study to assess the costs of supporting the BAMC Partnership Program prompt the researcher to make the following recommendations:

- The BAMC Partnership Program Manager should adopt the Variable Cost Model used in this study to complete future Partnership cost analyses. The current cost assessment methodology, which incorporates all fixed costs, but only some variable costs, inaccurately reflects the costs of the Partnership Program, whether viewed by individual clinic, or as a whole. On average, it exaggerates support expenses and consequently, overestimates the cost of the entire program.
- It is particularly important that BAMC discard the use of average Partnership support costs per visit (other than to meet official reporting requirements) when calculating total Partnership costs. Clinic-specific support costs provide detailed information which is considerably more useful in determining the cost-effectiveness of particular Partnership Agreements.
- BAMC should accelerate the procurement of information systems which will allow managers to accurately assess the cost

of providing ancillary services, particularly Pharmacy. Center managers are currently unable to easily ascertain the direct costs of providing Pharmacy support to the Partnership Program; neither can they establish physician profiles or drug utilization trends. The results of this study demonstrate that Pharmacy costs alone can significantly influence the cost-effectiveness of Partnership Agreements.

- Officials responsible for determining the cost supporting local Partnership Agreements should construct facility-specific models which identify the particular costs inherent to their organizations. Each MEPR account must be carefully examined to identify potential variable costs which are attributable to the Partnership Program. Program managers must tailor the cost assessment model so that it measures incremental increases in administrative and ancillary support costs peculiar to a given Agreement. Each model must account for the variable costs associated with supporting the Partnership Program including: additional hiring of personnel; equipment procurement; overtime; supplemental care expenditures; supplies; and ancillary services.

- Health Services Command should publish guidance which clearly explains how MEPRS should be used to determine Partnership support costs. The guidance should include a description of those MEPR codes which are likely to contain variable costs and sample cost assessment methodologies keyed to specific Partnership Agreements. For example, one sample methodology might list those MEPR codes which would be pertinent to the assessment of the support costs of an Internal Medicine Agreement for 2 Cardiologists who see outpatients only, make extensive use of special procedures (in addition to routine ancillary services), and require the use of 5 hours overtime per week divided equally between a civilian Electrocardiography technologist and Medical Records clerk. Such guidance from HSC, which includes specific illustrations of variable cost computation using MEPRS, will assist Partnership Program managers and respond to the first recommendation of the Lewin/ICF report which states "the first task required, we believe, is to supplement the information provided to the MTF's with more detailed guidance for Program implementation..." (1989).

- The Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) should provide more information pertaining to the use of ancillary services. In particular, OCHAMPUS should provide information regarding the per visit costs of Pharmacy by clinical specialty.

Further study of the Partnership Program at BAMC should focus on determining whether CHAMPUS utilization rates have been influenced by the availability of Partnership physicians.

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1. Depreciation EA

FUNCTION: This account is provided to accumulate the expenses associated with the investment costs incurred for depreciable properties in use. Depreciable properties will only include costs for modernization and replacement equipment. The purpose of this account is to facilitate assignment of the depreciable cost of property to accounting periods and to final operating expense accounts within each period. This account will not accumulate costs during the fiscal year in which the investment equipment is expensed, and does not accumulate expenses for equipment below the dollar level used in the definition of investment equipment (see Glossary). Acquisitions below the investment dollar threshold shall be charged to the receiving accounts as operating expenses.

COSTS: The only investment equipment depreciation expenses of the medical treatment facilities shall be those for in-use replacement and modernization investment equipment. Specifically excluded are investment expenses associated with plant equipment necessary for: (1) new and expanded facilities; (2) real property installed equipment (such as environmental control units and elevators); (3) War Readiness Materiel; and (4) support of any Program Elements other than "Care in Defense Facilities," PEC 877110; "Other Medical Activities," PEC 877140; "Dental Activities," PEC 877150; "Audiovisual - Medical," PEC 877900; and "Station Hospitals," PEC 877920.

PERFORMANCE FACTOR: Not applicable.

ASSIGNMENT PROCEDURE: The following procedure reflects the depreciation expense of investment equipment acquisitions to accounts of medical treatment facilities. Each DoD Component shall ensure that a set of records is established for each fixed medical or dental treatment facility under its control. Each facility's record will show the original dollar value of acquisitions of modernization and replacement investment equipment for each of the last eight fiscal years. Each fiscal year's aquisitions shall be broken down into the following categories:

a. Dental Care (PEC 877150)
b. All other investment equipment in support of Inpatient Care, Ambulatory Care, Ancillary Services, and Support Services (PECs 877110 and 877920)
c. Special Programs (PECs as appropriate)

At the end of each fiscal year, the cost of the investment item acquisitions (by the categories shown) for that year shall be added to the present category totals, and the oldest year's totals as well as the dollar value of any equipment transferred out or surveyed due to theft, disappearance, or destruction shall be subtracted. The new total for each category will be divided by 8 for inclusion in their respective cost assignment methodology as the current fiscal year's depreciation expense. The assignments to Dental Care will thereby be specified. Each medical treatment facility shall use the following percentages to distribute depreciation expense between Inpatient Care and Ambulatory Care accounts:

Average Daily Patient Load	Distribution Percentage Inpatient	Ambulatory
Greater than 250 ADPL[1]	60	40
Between 50 and 250 ADPL	50	50
Less than 50 ADPL	40	60
Clinics		100%

NOTE: Tri-Service Medical Information System (TRIMIS) or other Military Department funded automated medical system hardware and associated communications investment equipment installed within the medical treatment facility will be included in the depreciation amounts gathered for the appropriate category.

a. Inpatient Depreciation EAA

FUNCTION: This account is provided to accumulate expenses associated with the investment costs incurred for depreciable properties used in supporting inpatient work centers. The purpose of this account is to facilitate assignment of the depreciable cost of property to accounting periods and to Inpatient Care final operating expense accounts within each period.
COST: As computed from the cost assignment procedure described above.
ASSIGNMENT PROCEDURE: The following procedures reflect the depreciation expense of investment equipment acquisitions to inpatient final operating accounts of the medical treatment facility. Assignment of the depreciation expense during the reporting period will then be based on the ratio of occupied bed days for each inpatient account to the total occupied bed days in the medical treatment facility.

b. Ambulatory Depreciation EAB

FUNCTION: This account is provided to accumulate expenses associated with the investment costs incurred for depreciable properties used in supporting ambulatory work centers. The purpose of this account is to facilitate assignment of the depreciable cost of property to accounting periods and to Ambulatory Care final operating expense accounts within each period.
COST: As computed from the cost assignment procedure described above.
ASSIGNMENT PROCEDURE: The following procedures reflect the depreciation expense of investment equipment acquisitions to ambulatory final operating accounts of the medical treatment facility. Assignment of the depreciation expense during the reporting period will then be based on the ratio of total visits to each Ambulatory Care account to the total number of visits (inpatient and outpatient) to the medical treatment facility.

[1] Average Daily Patient Load

c. Dental Depreciation EAC

FUNCTION: This account is provided to accumulate expenses associated with the investment costs incurred for depreciable properties used in supporting dental work centers. The purpose of this account is to facilitate assignment of the depreciable cost of property to accounting periods and to Dental Care final operating expense accounts within each period.
COST: As totaled from the local records described above.
ASSIGNMENT PROCEDURE: The following procedures reflect the depreciation expense of investment equipment acquisitions to dental final operating accounts of the medical or dental treatment facility. Assignment of the depreciation expense during the reporting period will then be based on the ratio of dollar value of inventory of depreciable dental equipment for each Dental Care subaccount to the total value of dental depreciable equipment in the medical or dental treatment facility.

d. Special Programs Depreciation EAD

FUNCTION: This account is provided to accumulate expenses associated with the investment costs incurred for depreciable properties used in supporting Special Program work centers. The purpose of this account is to facilitate assignment of the depreciable cost of property to accounting periods and to Special Program final operating expense accounts within each period.
COST: As totaled from the cost of investment equipment used by Special Program accounts.
ASSIGNMENT PROCEDURE: Assignment of the depreciation expense during the reporting period will then be based on the actual records of investment equipment used by the various Special Programs accounts.

2. Command, Management, and Administration EB

FUNCTION: The Command, Management, and Administration account summarizes expenses incurred as a result of providing overall command, policy, management, and operation of the medical treatment facility. The accounts summarized are:

Command
Special Staff
Administration
Clinical Management

COSTS: The Command, Management, and Administration account shall summarize all operating expenses incurred by the accounts listed above. The aggregate of expenses in the Command, Management, and Administration account shall be assigned through a stepdown process to other Support Services, Ancillary Services, and the final operating expense accounts.

a. Command EBA

FUNCTION: The commander of a medical facility commands, organizes, administers, and supervises all professional and administrative aspects of that facility; exercises command jurisdiction over all personnel assigned or attached to the medical facility; determines the facility's medical capability in relation to available medical service officers, supporting staff and facilities; implements directed programs; is responsible for the care, treatment, and welfare of all patients to comply with the requirements set by generally accepted standards of hospital operations as practiced in the United States. The commander delegates authority to his immediate staff to assist him in performing his responsibilities. The functional elements listed below by Military Department will be included in this expense account;

ARMY

Commander, Deputy Commander for Clinical Services, Deputy Commander for Administration, Command Sergeant Major and their immediate secretarial and administrative staff.

Commander, Army Health Clinics when so designated. (Excludes DENTAC Commanders, See 2, CA-Dental Services).

NAVY

Commanding Officer, Executive Officer, Command Master Chief and their immediate secretarial and administrative staff.

AIR FORCE

Commander, Deputy Commander (when authorized), Director/Chief, Hospital Services (when functioning as the Commander), Administrator, Associate Administrator (when authorized), Medical Squadron Section Commander, First Sergeant and their immediate secretarial and administrative staff.

COSTS: The Command account shall be charged with all operating expenses incurred in operating and maintaining the command function. These costs include personnel costs, supplies, equipment, and any other costs separately identified in support of command activities.
PERFORMANCE FACTOR: Full Time Equivalent (FTE) Man-Months.
ASSIGNMENT PROCEDURE: The Command expenses shall be assigned based on a ratio of each receiving account's FTE man-months to the total FTE man-months in all receiving accounts after the personnel distribution (See Chapter 3), but before any purification process.

b. Special Staff EBB

FUNCTION: Special Staff provides specialized staff services to command, command staff, assigned/attached personnel, and the patient population of the medical treatment facility. Establishment of discrete special staff work centers will vary depending on scope, size, complexity, and Military Department of the MTF. The work centers listed below by Military Department are examples of those to be included in this expense account.

ARMY

EBBH

- Public Affairs
- Inspector General
- Legal Services
- Religious Activities
- Internal Review
- Quality Assurance/Risk Management
- Infection Control

EBBH Health Promotion Program

NAVY

- Public Affairs Officer
- Equal Employment Opportunity
- Religious Activities
- Internal Review
- American Red Cross Field Director
- Quality Assurance Coordinator
- Infection Control

AIR FORCE

- Legal Services
- Chaplain Services
- Quality Assurance and Risk Management Programs
- Health Promotion Program
- Infection Control

COSTS: The Special Staff account shall be charged with all the operating expenses incurred in operating and maintaining the special staff function. These costs include personnel costs, supplies, equipment, and any other costs separately identified in support of special staff activities.

PERFORMANCE FACTOR: Full Time Equivalent (FTE) Man-Months
ASSIGNMENT PROCEDURE: The Special Staff expenses shall be assigned based on a ratio of each receiving account's FTE man-months to the total FTE man-months in all receiving accounts after the personnel distribution (See Chapter 3), but before any purification.

c. Administration EBC

FUNCTION: Administrative support is responsible for financial management, personnel management, information systems, manpower management services, and administration. Establishment of discrete special work centers will vary depending on scope, size, and complexity of the MTF mission.
COSTS: The Administration account shall be charged with those expenses that directly support operating and maintaining administrative support. These costs include personnel costs, supplies, equipment, travel, and any other costs separately identified in support of administrative activities.
PERFORMANCE FACTOR: Full Time Equivalent (FTE) Man-Months.
ASSIGNMENT PROCEDURE: The Administration expenses shall be assigned based on a ratio of each receiving account's FTE man-months to the total FTE man-months in all receiving accounts after the personnel distribution (See Chapter 3), but before any purification.

d. Clinical Management EBD

FUNCTION: Clinical Management is responsibile for planning, directing, and coordinating direct patient care work centers. The work centers listed below are some examples to be included in this expense account. Establishment of discrete special work centers will vary depending on scope, size, and complexity of the MTF mission. Work centers will include secretarial and immediate administative support personnel. This account excludes chiefs of departments for ancillary services.

ARMY

Chief, Dept of Medical Services
Chief, Dept of Surgical Services
Chief, Dept of Nursing Services
Asst Chief, Dept of Nursing Services (Days, Evenings & Nights)
Chief, Clinical Nursing Services
Chief, Medical Nursing Section
Chief, Surgical Nursing Section

NAVY

Director, Nursing Services
Director, Medical Services
Director, Surgical Services
Heads of Departments where more than one work center is managed

AIR FORCE

Director/Chief, Hospital Services (except when functioning as the Commander, see EBA-Command).

Department Chairman and immediate support staff when the functional account is authorized.

Chairman, Department of Nursing Services

COSTS: The Clinical Management account shall be charged with those expenses that directly support the operating and maintaining of the respective clincical management activity. These costs include personnel costs, supplies, equipment, and any other costs separately identified in support of clinical management.

PERFORMANCE FACTOR: Full Time Equivalent (FTE) Man-Months.

ASSIGNMENT PROCEDURE: Clinical Management aggregate expenses shall be assigned based on the ratio of FTEs for individuals supervised in each receiving account to the total FTEs within the work center.

3. Support Services - Nonreimbursable EC

FUNCTION: The Support Services - Nonreimbursable subaccounts comprise public works/civil engineering, personnel support services, communications, and other support activities which are managed and provided by organizations that are not part of the medical treatment facility (MTF). Since services are received without direct expense to the MTF, an estimate of the MTF's prorata share of the cost of services will be made. The following accounts may be established depending on facility requirements:

Plant Management - Nonreimbursable
Operation of Utilities - Nonreimbursable
Maintenance of Real Property - Nonreimbursable
Minor Construction - Nonreimbursable
Other Engineering Support - Nonreimbursable
Leases of Real Property - Nonreimbursable
Transportation - Nonreimbursable
Fire Protection - Nonreimbursable
Police Protection - Nonreimbursable
Communications - Nonreimbursable
Other Base Support Services - Nonreimbursable

COSTS: At those facilities with large, complex public works/civil engineering services, only those expenses (including overhead) that directly support the medical mission are chargeable to expense accounts of the medical facility. The use of the expression "Non-reimbursable" as part of the subaccount titles is meant to restrict their use to those circumstances where another organization provides the service through its own staff or contracts for the service at no cost to the facility. Examples of expenses which are not chargeable to the medical facility are those that are incurred to support clubs and messes; unaccompanied personnel housing; military family housing; exchanges; tactical units, including tactical medical units; and commissaries.

a. Plant Management - Nonreimbursable ECA

FUNCTION: Plant Management provides the civil engineering function to ensure planning and programming for the maintenance and improvement of medical facilities.
COSTS: Plant Management includes expenses incurred to provide the civil engineering function, whether provided by the host installation or purchased by contract on a nonreimbursable basis.
PERFORMANCE FACTOR: Not applicable.
ASSIGNMENT PROCEDURE: Plant Management subaccount aggregate expenses are assigned based on a ratio of each receiving account's square footage to the total square footage in the medical facility.

b. Operation of Utilities - Nonreimbursable ECB

FUNCTION: Operation of Utilities subaccount includes electricity, water, heat, sewage, and cable TV services provided to the MTF.
COSTS: Operation of Utilities includes the medical facility's share of the operation of the utilities system, that is, electricity, water, heat, sewage, and cable TV, provided by the host installation on nonreimbursable basis.
PERFORMANCE FACTOR: Not applicable.
ASSIGNMENT PROCEDURE: Operation of Utilities subaccount aggregate expenses are assigned based on a ratio of each receiving account's square footage to the total square footage in the medical facility.

c. Maintenance of Real Property - Nonreimbursable ECC

FUNCTION: Maintenance of Real Property - Nonreimbursable subaccount is responsible for accumulating the expenses for alterations, maintenance, repair, and management of medical facility real property, to include installed equipment when performed by host installation engineering personnel or by contract on a nonreimbursable basis.
COSTS: Maintenance of Real Property - Nonreimbursable includes only those expenses applicable to the medical facility that are not financed from Program Element 877940.
PEFORMANCE FACTOR: Not applicable.
ASSIGNMENT PROCEDURE: That portion of the Maintenance of Real Property subaccount expenses that cannot be identified with a specific work center is assigned based on a ratio of each receiving account's square footage to the total square footage in the medical facility. Maintenance of Real Property expenses that can be identified with a specific work center are assigned based on a ratio of hours or percentage of services received by each receiving account to the total hours or percentage of service received by the medical facility.

d. Minor Construction - Nonreimbursable ECD

FUNCTION: Minor Construction - Nonreimbursable subaccount is responsible for accumulating expenses for minor construction of facilities when performed by host installation engineering personnel on a nonreimbursable basis.
COSTS: Minor Construction - Nonreimbursable includes only those expenses applicable to the medical facility that are free receipts to the MTF. This account does not include expenses of "Urgent Minor Construction" that are charged to the Special Program account.
*
PERFORMANCE FACTOR: Not applicable.
ASSIGNMENT PROCEDURE: Minor Construction expenses are assigned based on a ratio of hours or percentage of service received by each receiving account to the total hours or percentage of service received by the medical facility.

e. Other Engineering Support - Nonreimbursable ECE

FUNCTION: The Other Engineering Support - Nonreimbursable includes other miscellaneous engineering support furnished the medical facility on a nonreimbursable basis. Examples are: collection of trash, refuse and garbage; inspecting and servicing of elevators, sprinkling systems, and boilers; grass cutting; tree and shrub services; insect and rodent control; and snow and sand removal and ice removal.

COSTS: This subaccount includes all expenses for the services described above.
PERFORMANCE FACTORS: Not applicable.
ASSIGNMENT PROCEDURE: Other Engineering Support subaccount aggregate expenses are assigned based on a ratio of each receiving account's square footage to the total square footage in the medical facility.

f. Leases of Real Property - Nonreimbursable ECF

FUNCTION: Leases of Real Property includes lease and rental charges incurred by the host installation to provide facilities for routine MTF services on a nonreimbursable basis.
COSTS: The subaccount includes lease and rental charges incurred to provide additional facilities for routine services. Excludes: rental of equipment; rental or lease of facilities in emergency or contingency operations (See account Contingency and Emergency Operations under Special Programs).
PERFORMANCE FACTOR: Not applicable.
ASSIGNMENT PROCEDURE: Leases of Real Property expenses are assigned to the accounts receiving the benefit. See page 3-12 for computation ratio.

g. Transportation - Nonreimbursable ECG

FUNCTION: Transportation includes all the expenses incurred for provision of transportation services by the host installation on a nonreimbursable basis.
COSTS: Includes only those transportation expenses provided by a host installation to the medical treatment facility on a nonreimbursable basis. Excludes: charges in support of emergency medical vehicles, ambulances, and patient transportation and shuttle vehicles, which are to be charged to the Patient Transportation or Contingency and Emergency Operations account.
PERFORMANCE FACTOR: Not applicable.
ASSIGNMENT PROCEDURE: Transportation expenses, except those for emergency medical vehicles, ambulances, and patient transportation and shuttle vehicles, are assigned based on a ratio of miles driven in vehicles serving each receiving account to the total miles driven in all vehicles serving the medical facility. An exception would be where the expenses can be specifically identified to an account, such as full-time use of a vehicle or vehicles by only one account. In that instance, cost of maintenance and operation of those vehicles is assigned to the account responsible for the vehicles. Expenses for maintenance and operation of emergency medical vehicles, ambulances, and patient transportation and shuttle vehicles are to be assigned to the Patient Transportation or Contingency and Emergency Operations account in the Special Programs section.

h. Fire Protection - Nonreimbursable ECH

FUNCTION: Fire Protection is responsible for the service of inspection and testing of fire alarm and suppression devices in the medical facilities; telecommunications connecting the medical facility with the fire fighters; and procurement, testing, and servicing fire extinguishers, and conducting fire drills in the medical faclity by the host installation on a nonreimbursable basis.
COSTS: Include only those fire protection expenses provided by a host installation to the medical treatment facility on a nonreimbursable basis.

PERFORMANCE FACTOR: Not applicable.
ASSIGNMENT PROCEDURE: The Fire Protection expenses shall be assigned based on a ratio of each receiving account's square footage to the total square footage of the medical facility.

i. Police Protection - Nonreimbursable ECI

FUNCTION: Police Protection is responsible for the safety and wellbeing of hospital patients, visitors and personnel (while at the hospital), and protects the medical facility's buildings and other facilities. It includes physical security of parking lots, surrounding grounds, and interiors of medical treatment facilities provided by a host installation on a nonreimbursable basis.
COSTS: Include only those police protection expenses provided by a host installation to the medical treatment facility on a nonreimbursable basis.
PERFORMANCE FACTOR: Not applicable.
ASSIGNMENT PROCEDURE: The Police Protection expenses shall be assigned based on a ratio of each receiving account's square footage to the total square footage of the medical facility.

j. Communications - Nonreimbursable ECJ

FUNCTION: This subaccount shall accumulate all expenses for communications services provided by a host installation to the medical treatment facility on a nonreimbursable basis.
COSTS: Include only those communications expenses provided by a host installation to the medical treatment facility on a nonreimbursable basis.
PERFORMANCE FACTOR: Not applicable.
ASSIGNMENT PROCEDURE: Expenses for communications are assigned based on a ratio of each receiving account's number of full-time equivalent work months (excluding patients) to the total number of full-time equivalent work months under all subaccounts.

k. Other Base Support Services - Nonreimbursable ECK

FUNCTION: This subaccount shall be used to accumulate expenses for other base support activities such as personnel support services (civilian and military personnel offices) and data automation provided by the host installation on a nonreimbursable basis.
COSTS: That portion of the expense of providing such services that is attributable to the medical treatment facility and its primary mission of health care delivery. Therefore, charges to this subaccount must be carefully reviewed to determine the expense assignable to the medical facility. In turn, these expenses must again be screened to determine patient care and nonpatient care expenses. The patient care expenses then shall be assigned to Inpatient, Ambulatory, Dental, Ancillary Services, and other Support Services accounts.
PERFORMANCE FACTORS: Not applicable.
ASSIGNMENT PROCEDURE: All expenses that are not appropriate charges to the medical facility are charged to Special Programs accounts. If a complex Public Works organization is existent, see "Base Operations - Medical Installations." Assignment procedure is the same as for account ECJ above.

4. Support Services - Funded/ Reimbursable ED

FUNCTION: The Support Services - Funded/Reimbursable subaccounts comprise public works/civil engineering, personnel support services, communications, and other support activities managed by the MTF or provided by the host installation on a reimbursable basis. The following accounts may be established depending on facility requirements:

Plant Management - Funded/Reimbursable
Operation of Utilities - Funded/Reimbursable
Maintenance of Real Property - Funded/Reimbursable
Minor Construction - Funded/Reimbursable
Other Engineering Support - Funded/Reimbursable
Leases of Real Property - Funded/Reimbursable
Transportation - Funded/Reimbursable
Fire Protection - Funded/Reimbursable
Police Protection - Funded/Reimbursable
Communications - Funded/Reimbursable
Other MTF Support Services - Funded/Reimbursable

COSTS: Only those expenses which are chargeable to expense accounts of the medical facility for services received in support of the medical mission are to be included in the subaccounts listed above. Examples of expenses which are NOT chargeable to the medical facility are those that are incurred to support clubs and messes; unaccompanied personnel housing; military family housing; exchanges; tactical units, including tactical medical units; and commissaries.

a. Plant Management - Funded/Reimbursable EDA

FUNCTION: Plant Management provides necessary liaison with the installation civil engineering function to ensure planning and programming for the maintenance and improvement of medical facilities.
COSTS: Plant Management includes expenses incurred to provide necessary liaison with the installation civil engineering function.
PERFORMANCE FACTOR: Not applicable.
ASSIGNMENT PROCEDURE: Plant Management subaccount aggregate expenses are assigned based on a ratio of each receiving account's square footage to the total square footage in the medical facility.

b. Operation of Utilities - Funded/Reimbursable EDB

FUNCTION: Operation of Utilities subaccount includes electricity, water, heat, sewage, and cable TV services provided by or to the medical treatment facility on a funded/reimbursable basis.
COSTS: Operation of Utilities - Funded/Reimbursable includes the medical facility's share of a utilities system operated and maintained by the MTF. Electricity, water, heat, sewage, and cable TV services provided to other base agencies will not be charged to the MTF.
PERFORMANCE FACTOR: Not applicable.

ASSIGNMENT PROCEDURE: Operation of Utilities subaccount aggregate expenses are assigned based on a ratio of each receiving account's square footage to the total square footage in the medical facility. Expenses for utilities provided to other base organizations that are not reimbursed will be charged to the Base Operations - Medical Installations.

c. Maintenance of Real Property - Funded/Reimbursable EDC

FUNCTION: Maintenance of Real Property - Funded/Reimbursable subaccount is responsible for accumulating the expenses for alterations, maintenance, repair, and management of medical facility real property, to include installed equipment, on a funded/reimbursable basis.
COSTS: Maintenance of Real Property - Funded/Reimbursable includes only those expenses applicable to the medical facility that are financed from Program Element 877940.
PERFORMANCE FACTOR: Not applicable.
ASSIGNMENT PROCEDURE: That portion of the Maintenance of Real Property subaccount expenses that cannot be identified with a specific work center is assigned based on a ratio of each receiving account's square footage to the total square footage in the medical facility. Maintenance of Real Property expenses that can be identified with a specific work center are assigned based on a ratio of hours or percentage of services received by each receiving account to the total hours or percentage of service performed by the medical facility. Where maintenance or repair is provided by contract, these expenses are assigned to the accounts receiving the benefit.

d. Minor Construction - Funded/Reimbursable EDD

FUNCTION: Minor Construction - Funded/Reimbursable subaccount is responsible for accumulating expenses for minor construction of facilities when performed on a funded/reimbursable basis.
COSTS: Minor Construction - Funded/Reimbursable includes only those expenses applicable to the medical facility that are financed from the applicable Operation and Maintenance Appropriation. This account does not include expenses of "Urgent Minor Construction" that are charged to the Special Program account.
PERFORMANCE FACTOR: Not applicable.
ASSIGNMENT PROCEDURE: Minor Construction expenses are assigned based on a ratio of hours on percentage of service received by each receiving account to the total hours or percentage of service performed by the medical facility. Where minor construction is provided by contract, these expenses are assigned to the accounts receiving the benefit.

e. Other Engineering Support - Funded/Reimbursable EDE

FUNCTION: The Other Engineering Support - Funded/Reimbursable subaccount includes the other miscellaneous engineering support furnished on a funded/reimbursable basis. Examples are: collection of trash, refuse and garbage; inspecting and servicing of elevators, sprinkling systems, and boilers; grass cutting; tree and shrub services; insect and rodent control; and snow and sand removal and ice removal.
*
COSTS: This subaccount includes all expenses for the services described above.

PERFORMANCE FACTOR: Not applicable.
ASSIGNMENT PROCEDURE: Other Engineering Support subaccount aggregate expenses are assigned based on a ratio of each receiving account's square footage to the total square footage in the medical facility.

f. Lease of Real Property - Funded/Reimbursable EDF

FUNCTION: Lease of Real Property - Funded/Reimbursable subaccount includes lease and rental services obtained on a funded/reimbursable basis.
COSTS: This subaccount includes lease and rental charges incurred to provide additional facilities for routine services. Excludes: rental of equipment; rental or lease of facilities in emergency or contingency operations (See account Contingency and Emergency Operations under Special Programs).
PERFORMANCE FACTOR: Not applicable.
ASSIGNMENT PROCEDURE: Lease of Real Property expenses are assigned to the accounts receiving the benefit. See page 3-13 for computation procedure.

g. Transportation - Funded/Reimbursable EDG

FUNCTION: Transportation includes all the expenses incurred for automative operation and maintenance and the administration of garage and dispatching activities in support of the medical mission on a funded/reimbursable basis.
COSTS: The expenses include personnel expenses of drivers assigned to this function; maintenance of vehicles (including contracts); petroleum, oils, and lubricants; vehicle rental and leases; and bridge/tunnel/highway tolls.
EXCLUDES: personnel expenses and operation and maintenance expenses in support of emergency medical vehicles, ambulances, and patient transportation and shuttle vehicles.
PERFORMANCE FACTOR: Not applicable.
ASSIGNMENT PROCEDURE: Transportation expenses, except those for emergency medical vehicles, ambulances, and patient transportation and shuttle vehicles, are assigned based on a ratio of miles driven in vehicles serving each receiving account to the total miles driven in all vehicles serving the medical facility. An exception would be where the expenses can be specifically identified to an account such a full-time use of a vehicle or vehicles by only one account. In that instance, cost of maintenance and operation of those vehicles is assigned to the accounts responsible for the vehicles. Expenses for the maintenance and operation of emergency medical vehicles, ambulances, and patient transportation and shuttle vehicles are to be assigned to the Patient Transportation or Contingency and Emergency Operations account in the Special Program section.

h. Fire Protection - Funded/Reimbursable EDH

FUNCTION: Fire Protection is responsible for the services of inspection and testing of fire alarm and suppression devices in the medical facilities; telecommunications connecting the medical facility with the fire fighters; and procurement, testing and servicing fire extinguishers, and conducting fire drills in the medical facility on a funded/reimbursable basis.
COSTS: Those expenses that can be readily identified as protecting the medical facility shall be charged to this work center account. Expenses are

those operating expenses for personnel, material, and services incurred for the operation and maintenance of the function. Exclude the cost of standby fire fighting capability (personnel, facilities, and vehicles). The aggregate expenses shall be assigned through a stepdown process to other Support Services, Ancillary Services, and final operating expense accounts.
PERFORMANCE FACTOR: Not applicable.
ASSIGNMENT PROCEDURES: The Fire Protection expenses shall be assigned based on a ratio of each receiving account's square footage to the total square footage of the medical facility. Those expenses that are not appropriately charged to patient care shall be charged to the Base Operations Medical Installations accounts or to other Special Programs accounts. The functional elements (from whatever provider source) are those mentioned above, plus those other personnel support services necessary to support the military and civilian personnel of the military command (such as those depicted in Program Element "Base Operations - Health Care," PEC 87796A).

i. Police Protection - Funded/Reimbursable EDI

FUNCTION: Police Protection is responsible for the safety and wellbeing of hospital patients, visitors and personnel (while at the hospital), and protects the medical facility's buildings and other facilities on a funded/reimbursable basis. It includes physical security of parking lots, surrounding grounds, and interiors of medical treatment facilities.
*
COSTS: Those expenses that can be readily identified as protecting the medical treatment facility shall be charged to this work center account. Expenses are those operating expenses of personnel, materiel, and services incurred in operating and maintaining the function. Exclude the costs of all law enforcement activities other than those described in the "Function" statement. The aggregate expenses shall be assigned through a stepdown process to other Support Services, Ancillary Services, and final operating expense accounts.
PERFORMANCE FACTOR: Not applicable.
ASSIGNMENT PROCEDURE: The Police Protection expenses shall be assigned based on a ratio of each receiving account's square footage to the total square footage of the medical facility.

j. Communications - Funded/Reimbursable EDJ

FUNCTION: This subaccount shall accumulate all expenses for communications service provided on a funded/reimbursable basis.
COSTS: Include only those communications expenses provided on a funded/reimbursable basis.
PERFORMANCE FACTOR: Not applicable.
ASSIGNMENT PROCEDURE: Expenses for communications are assigned based on a ratio of each receiving account's number of full-time equivalent work months (excluding patients) to the total number of full-time equivalent work months under all subaccounts.

k. Other MTF Support Services Funded/Reimbursable EDK

FUNCTION: This subaccount shall be used to accumulate expenses for other MTF support activities such as personnel support services (civilian and military personnel offices) provided on a funded/reimbursable basis.

COSTS: That portion of the expense of providing such services that is attributable to the medical treatment facility and its primary mission of health care delivery. Therefore, charges to this subaccount must be carefully reviewed to determine the expense assignable to the medical facility. In turn, these expenses must again be screened to determine patient care and nonpatient care expenses. The patient care expenses then shall be assigned to Inpatient, Ambulatory, Dental, Ancillary Services, and other Support Services accounts.

PERFORMANCE FACTOR: Not applicable.

ASSIGNMENT PROCEDURE: Expenses are assigned based on a ratio of each receiving account's number of full-time equivalent work months (excluding patients) to the total number of full-time equivalent work months under all subaccounts.

5. Materiel Services EE

FUNCTION: The Materiel Services account provides or arranges for the supplies, equipment, and certain services necessary to support the mission of the medical facility. The basic responsibilities are: procurement, inventory control, receipt, storage, quality assurance, issue, turn in, disposition, property accounting, and reporting actions for designated medical and nonmedical supplies and equipment required in support of the medical mission; installation management of the medical stock fund; management and control of medical organization in-use property through authorization, property accounting, reporting and budgetary procedures; and planning, pre-positioning, and managing the installation medical war readiness materiel program. Also this function performs (or acts as chargeable account for overhead charges from the base operations accounts for) the general support stock fund and subsistence stock fund management functions.

COSTS: The Materiel Services account shall be charged with all operating expenses incurred in operating and maintaining the function. The aggregate of these expenses shall be assigned through the stepdown process to other Support Services, Ancillary Services, and final operating expense accounts, except contract (or installation provided) maintenance of equipment expenses, which shall be charged to the benefiting work center account responsible for the reparable equipment. Expenses incurred in the direct support of War Readiness Materiel/ Pre-positioned War Reserve Program and TOE Medical Units shall be identified, accumulated, and transferred to the Contingency and Emergency Operations account in the Special Programs section. The expenses incurred in regional/area support of other medical and nonmedical activities shall also be identified, accumulated, and transferred to the appropriate Special Programs account.

PERFORMANCE FACTOR: Cost of supplies (except subsistence) and minor plant equipment issued.

ASSIGNMENT PROCEDURE: Expenses not directly charged are assigned based on a ratio of each receiving account's combined expenses for supplies received (except subsistence) and minor plant equipment received to the total combined expenses for supplies (except subsistence) and minor plant equipment received from Materiel Services of the medical facility. Note above exception for equipment maintained by contract or provided by an installation organization.

6. Housekeeping EF

FUNCTION: The Housekeeping service is responsible for maintaining the interior of the medical facility at the highest level of cleanliness and sanitation achievable, either by in-house or contract services. Also the service is responsible for snow and debris removal from entrances and walks adjacent to buildings and trash removal from buildings.
COSTS: The Housekeeping service shall be charged with all operating expenses incurred in operating and maintaining the function. The aggregate of these expenses shall be assigned through the stepdown process to other Support Services, Ancillary Services, and final operating expense accounts. The assignable expenses include those for personnel and material for providing custodial and janitorial services to the medical facility, either by contract or by in-house personnel who are authorized and assigned to this function as a primary duty. Exclude any personnel or material expenses incurred in support of unaccompanied personnel housing or family housing or any other nonmedical organizations or functions.
PERFORMANCE FACTOR: Square footage cleaned
ASSIGNMENT PROCEDURE: Expenses not directly charged are assigned based on the ratio of each receiving account's square footage cleaned to the total square footage cleaned in the medical facility.

a. Housekeeping - In House EFA

FUNCTION: The Housekeeping service is responsible for maintaining the interior of the medical facility at the highest level of cleanliness and sanitation achievable by in-house services. Also the service is responsible for snow and debris removal from entrances and walks adjacent to buildings and trash removal from buildings.
COSTS: The Housekeeping service shall be charged with all operating expenses incurred in operating and maintaining the function. The aggregate of these expenses shall be assigned through the stepdown process to other Support Services, Ancillary Services, and final operating expense accounts. The assignable expenses include those for personnel and material for providing custodial and janitorial services to the medical facility by in-house personnel who are authorized and assigned to this function as a primary duty. Exclude any personnel or material expenses incurred in support of unaccompanied personnel housing or family housing or any other nonmedical organizations or functions.
PERFORMANCE FACTOR: Square footage cleaned.
ASSIGNMENT PROCEDURE: Expenses not directly charged are assigned based on the ratio of each receiving account's square footage cleaned to the total square footage cleaned in the medical facility.

b. Housekeeping - Contract EFB

FUNCTION: The Housekeeping service is responsible for maintaining the interior of the medical facility at the highest level of cleanliness and sanitation achievable by contract services. Also the service is responsible for snow and debris removal from entrances and walks adjacent to buildings and trash removal from buildings.
COSTS: The Housekeeping service shall be charged with all operating expenses incurred in operating and maintaining the function by contract. The aggregate of these expenses shall be assigned through the stepdown process to other Support Services, Ancillary Services, and final operating expense accounts. The assignable expenses include those for personnel and material for providing custodial and janitorial services to the medical facility by contract personnel who are authorized and assigned to this function as a primary duty. Exclude any personnel or material expenses incurred in support of unaccompanied personnel housing or family housing or any other nonmedical organizations or functions.
PERFORMANCE FACTOR: Square footage cleaned.
ASSIGNMENT PROCEDURE: Expenses not directly charged are assigned based on ratio of each receiving account's square footage cleaned to the total square footage cleaned in the medical facility.

7. Biomedical Equipment Repair EG

FUNCTION: The Biomedical Equipment Repair Service provides preventive maintenance, inspection, and repair of medical and dental equipment; conducts a systematic inspection of equipment to determine operational status, and assigns serviceability condition codes to equipment; performs scheduled preventive maintenance of medical and dental equipment; repairs or replaces worn or broken parts; rebuilds and fabricates equipment or components; modifies equipment and installs new equipment; inspects and tests contractor installed equipment; disassembles, packs, receives, and inspects equipment; maintains audio/video equipment; tests the ground contact alarm of the operating room electrical service and the conductivity of operating room floors; tests and performs preventive maintenance on War Readiness Materiel/Pre-positioned War Reserve; and monitors contract maintenance.
COSTS: Biomedical Equipment Repair shall be charged with all operating expenses incurred in operating and maintaining the function, except for directly identifiable medical and nonmedical equipment maintenance and repair services or contracts, which shall be charged directly to the account receiving the benefit of the services or contract. The aggregate of these expenses shall be assigned through a stepdown process to other Support Services, Ancillary Services, and final operating expense accounts. Expenses incurred in regional/area support to other medical and nonmedical activities shall be identified, accumulated, and transferred to the appropriate Special Programs account.
PERFORMANCE FACTOR: Hours of service.
ASSIGNMENT PROCEDURE: Personnel and overhead costs (bench stock, equipment, assigned costs from others) not directly charged shall be assigned based on a ratio of hours of service received by each receiving account to the total hours of service rendered to the medical facility. Costs of parts not maintained as bench stock shall be directly assigned to the receiving account responsible for the end item of equipment in which the supplies were used.

a. Biomedical Equipment Repair - In House EGA

FUNCTION: Biomedical Equipment Repair provides preventive maintenance, inspection and repair of medical and dental equipment; conducts a systematic inspection of equipment to determine operational status, and assigns serviceability condition codes to equipment; performs scheduled preventive maintenance of medical and dental equipment; repairs or replaces worn or broken parts; rebuilds and fabricates equipment or components; modifies equipment and installs new equipment; inspects and tests contractor installed equipment; disassembles, packs, receives, and inspects equipment; maintains audio/video equipment; tests the ground contact alarm of the operating room electrical service and the conductivity of operating room floors; tests and performs preventive maintenance on War Readiness Materiel/Pre-positioned War Reserve; and monitors contract maintenance.

COSTS: Biomedical Equipment Repair shall be charged with all operating expenses incurred in operating and maintaining the in-house function, except for directly identifiable medical and nonmedical equipment maintenance and repair by in-house services, which shall be charged directly to the account receiving the benefit of the in-house services. The aggregate of these expenses shall be assigned through a stepdown process to other Support Services, Ancillary Services, and final operating expense accounts. Expenses incurred in regional/area support to other medical and nonmedical activities shall be identified, accumulated, and transferred to the appropriate Special Programs account.
PERFORMANCE FACTOR: Hours of service.
ASSIGNMENT PROCEDURE: Personnel and overhead costs (bench stock, equipment, assigned costs from others) not directly charged shall be assigned based on a ratio of hours of service received by each receiving account to the total hours of service rendered to the medical facility. Costs of parts not maintained as bench stock shall be directly assigned to the receiving account responsible for the end item of equipment in which the supplies were used.

b. Biomedical Equipment Repair - Contract EGB

FUNCTION: Biomedical Equipment Repair provides preventive maintenance, inspection and repair of medical and dental equipment; conducts a systematic inspection of equipment to determine operational status and assigns serviceability condition codes to equipment; performs scheduled preventive maintenance of medical and dental equipment; repairs or replaces worn or broken parts; rebuilds and fabricates equipment or components; modifies equipment and installs new equipment; inspects and tests contractor installed equipment; disassembles, packs, receives, and inspects equipment; maintains audio/video equipment; tests the ground contact alarm of the operating room electrical service and the conductivity of operating room floors; tests and performs preventive maintenance on War Readiness Materiel/Pre-positioned War Reserve; and monitors contract maintenance.
COSTS: Biomedical Equipment Repair shall be charged with all operating expenses incurred in operating and maintaining the function, by contract except for directly identifiable medical and nonmedical equipment maintenance and repair contracts, which shall be charged directly to the account receiving the benefit of the contract. The aggregate of these expenses shall be assigned through a stepdown process to other Support Services, Ancillary Services, and final operating expense accounts. Expenses incurred in regional/area support to other medical and nonmedical activities shall be identified, accumulated, and transferred to the appropriate Special Programs account.
PERFORMANCE FACTOR: Hours of service.
ASSIGNMENT PROCEDURE: Personnel and overhead costs (bench stock, equipment, assigned costs from others) not directly charged shall be assigned based on a ratio of hours of service received by each receiving account to the total hours of service rendered to the medical facility. Costs of parts not maintained as bench stock shall be directly assigned to the receiving account responsible for the end item of equipment in which the supplies were used.

8. Laundry Service EH

FUNCTION: The Laundry Service is responsible for picking up, sorting, issuing, distributing, mending, washing, and processing in-service linens including uniforms and special linens. Dry cleaning services are also included.
COSTS: The Laundry Service shall be charged with all operating expenses incurred in operating and maintaining the function. The aggregate of these expenses shall be assigned through a stepdown process to other Support Services, Ancillary Services, and final operating expense accounts. Those expenses associated with the support of unaccompanied personnel housing or other nonmedical organizations or functions are charged to base operations accounts (see "Base Operations - Medical Installation" in the Special Programs section and "Base Operations - Health Care," PEC 87796A). The expenses to be assigned include all linen, laundry, and dry cleaning expenses associated with a contract or a Government-operated facility, including personnel costs required for the storage, issue, and repair of textiles used in the medical facility and costs of initial and replacement hospital linen items and personal retention clothing items. Personal retention clothing items are white trousers and shirts for technicians and food service personnel, nurses' uniforms, dentists' smocks, physicians' coats, and the like.
PERFORMANCE FACTOR: Pounds of laundry processed.
ASSIGNMENT PROCEDURE: Expenses not directly charged shall be assigned based on a ratio of pounds of laundry processed for each receiving account to the total pounds of laundry processed for the medical facility. "Pieces of laundry" may be used as an alternate performance factor and assignment basis only if to convert to "pounds of laundry processed" is prohibitive in cost or prohibited by contract. "Pounds of laundry processed" is the preferred measure and should be used whenever possible.

a. Laundry Service - In House EHA

FUNCTION: The Laundry Service is responsible for picking up, sorting, issuing, distributing, mending, washing, and processing in-service linens including uniforms and special linens. Dry cleaning services are also included.
COSTS: The Laundry Service shall be charged with all operating expenses incurred in operating and maintaining the in-hourse function. The aggregate of these expenses shall be assigned through a step down process to other Support Services, Ancillary Services, and final operating expense accounts. Those expenses associated with the support of unaccompanied personnel housing or other nonmedical organizations or functions are charged to base operations accounts (see "Base Operations - Medical Installation" in the Special Programs section and "Base Operations - Health Care," PEC 87796A). The expenses to be assigned include all linen, laundry, and dry cleaning expenses associated with a Government-operated facility, including personnel costs required for the storage, issue, and repair of textiles used in the medical facility and costs of initial and replacement hospital linen items and personal retention clothing items. Personal retention clothing items are white trousers and shirts for technicians and food service personnel, nurses' uniforms, dentists' smocks, physicians' coats and the like.

PERFORMANCE FACTOR: Pounds of laundry processed.
ASSIGNMENT PROCEDURE: Expenses not directly charged shall be assigned based on a ratio of pounds of laundry processed for each receiving account to the total pounds of laundry processed for the medical facility. "Pieces of laundry" may be used as an alternate performance factor and assignment basis only if to convert to "pounds of laundry processed" is not feasible. "Pounds of laundry processed" is the preferred measure and should be used whenever possible.

b. Laundry Service - Contract EHB

FUNCTION: The Laundry Service is responsible for picking up, sorting, issuing, distributing, mending, washing, and processing in-service linens including uniforms and special linens. Dry cleaning services are also included.
COSTS: The Laundry Service shall be charged with all operating expenses incurred in operating and maintaining the function by contract. The aggregate of these expenses shall be assigned through a stepdown process to other Support Services, Ancillary Services, and final operating expense accounts. Those expenses associated with the support of unaccompanied personnel housing or other nonmedical organizations or functions are charged to base operations accounts (see "Base Operations - Medical Installation" in the Special Programs section and "Base Operations - Health Care," PEC 87796A). The expenses to be assigned include all linen, laundry, and dry cleaning expenses associated with a contract; including personnel costs required for the storage, issue, and repair of textiles used in the medical facility and costs of initial and replacement hospital linen items and personal retention clothing items. Personal retention clothing items are white trousers and shirts for technicians and food service personnel, nurses' uniforms, dentists' smocks, physicians' coats and the like.
PERFORMANCE FACTOR: Pounds of laundry processed.
ASSIGNMENT PROCEDURE: Expenses not directly charged shall be assigned based on a ratio of pounds of laundry processed for each receiving account to the total pounds of laundry processed for the medical facility. "Pieces of laundry" may be used as an alternate performance factor and assignment basis only if to convert to "pounds of laundry processed" is prohibitive in cost or prohibited by contract. "Pounds of laundry processed" is the preferred measure and should be used whenever possible.

9. Inpatient Food Service EI

FUNCTION: Inpatient Food Service provides comprehensive nutritional care for inpatients including the preparation and service of food; routine dietary counseling of inpatients; nutritional education; dietetic treatment; and operation and maintenance of a food production service including kitchen, dining room, cafeteria, sanitation, food issue logistics, quality control, and subsistence.

COSTS: This function must be divided into at least two work center accounts: Dietetics and Subsistence. Dietetics includes all operating expenses incurred in operating and maintaining the function, except the cost of subsistence. Subsistence includes all expenses incurred for operating and maintaining the subsistence/provisions, with the exception of therapeutic diet supplements such as hyperalimentation solutions that are directly charged to the ordering inpatient work center. Exclude the expense of nursing service personnel who assist in the serving of food to patients. At those medical facilities where food service to patients is provided by an installation-operated food service facility, the expenses for such services provided at the medical facility are included in the assignment process, and will include the expenses for the food and its preparation as identified by the installation accounting system. In this case, all assigned expenses are assigned to Inpatient accounts. EXCEPTION: The expenses incurred to conduct a Nutrition Clinic shall be assigned to that clinic.

PERFORMANCE FACTOR: Rations served.

ASSIGNMENT PROCEDURE: The aggregate expenses to be assigned to direct patient care shall be based on the ratio of patient rations served to the total rations served in the medical facility. Patient rations are those served to patients, excluding transient patients, whether in the nursing units or in the hospital dining room. The assignment of the patient ration portion of the aggregate expenses to the receiving Inpatient accounts shall be based on the ratio of rations served to each inpatient receiving account to the total rations served to all inpatient receiving accounts in the medical facility. The remaining aggregate expenses shall be assigned to the Nonpatient Food Operations and Aeromedical Staging Facilities/Transient Patient Care accounts in the Special Programs section. The assignment to Aeromedical Staging Facilities/Transient Patient Care shall be based on the ratio of rations served to transient patients to the total rations served in the medical facility. All remaining expenses shall be assigned to the Nonpatient Food Operations account.

a. Dietetics - In House EIA

FUNCTION: Dietetics provides comprehensive nutritional care for inpatients including the preparation and service of food; routine dietary counseling of inpatients; nutritional education; dietetic treatment; and operation and maintenance of a food production service including kitchen, dining room, cafeteria, sanitation, and quality control.
COSTS: Dietetics includes all in-house operating expenses incurred in operating and maintaining the function, except the cost of subsistence. Exclude the expense of nursing service personnel who assist in the serving of food to patients. In this case, all assigned expenses are assigned to Inpatient accounts. EXCEPTION: The expenses incurred to conduct a Nutrition Clinic shall be assigned to that clinic.
PERFORMANCE FACTOR: Rations served.
ASSIGNMENT PROCEDURE: The aggregate expenses to be assigned to direct patient care shall be based on the ratio of patient rations served to the total rations served in the medical facility. Patient rations are those served to patients, excluding transient patients, whether in the nursing units or in the hospital dining room. The assignment of the patient ration portion of the aggregate expenses to the receiving Inpatient accounts shall be based on the ratio of rations served to each inpatient receiving account to the total rations served to all inpatient receiving accounts in the medical facility. The remaining aggregate expenses shall be assigned to the Nonpatient Food Operations and Aeromedical Staging Facilities/Transient Patient Care accounts in the Special Programs section. The assignment to Aeromedical Staging Facilities/Transient Patient Care shall be based on the ratio of rations served to transient patients to the total rations served in the medical facility. All remaining expenses shall be assigned to the Nonpatient Food Operations account.

b. Subsistence EIB

FUNCTION: This account is provied to accumulate the expenses associated with subsistence and food issue logistics.
COSTS: Subsistence includes all expenses incurred for operating and maintaining the subsistence/provisions with the exception of therapeutic diet supplements, such as hyperalimentation solutions that are directly charged to the ordering inpatient work center. Exclude the expense of nursing service personnel who assist in the serving of food to patients. At those medical facilities where food service to patients is provided by an installation operated food service facility, the expenses for such services provided at the medical facility are included in the assignment process and will include the expenses for the food and its preparation as identified by the installation accounting system. In this case, all assigned expenses are assigned to Inpatient accounts. EXCEPTION: The expenses incurred to conduct a Nutrition Clinic shall be assigned to that clinic.
PERFORMANCE FACTOR: Rations served.
ASSIGNMENT PROCEDURE: The aggregate expenses to be assigned to direct patient care shall be based on the ratio of patient rations served to the total rations served in the medical facility. Patient rations are those served to patients, excluding transient patients, whether in the nursing units or in the hospital dining room. The assignment of the patient ration portion of the aggregate expenses to the receiving Inpatient accounts shall be based on the ratio of rations served to each inpatient receiving account to the total rations served to all inpatient receiving accounts in the medical facility. The remaining aggregate expenses shall be assigned to the Nonpatient Food Operations and Aeromedical Staging Facilities/Transient Patient Care accounts in the Special Programs section. The assignment to Aeromedical Staging Facilities/Transient Patient Care shall be based on the ratio of rations served to transient patients to the total rations served in the medical facility. All remaining expenses shall be assigned to the Nonpatient Food Operations account.

c. Dietetics - Contract EIC

FUNCTION: Inpatient Food Service provides comprehensive nutritional care for inpatients including the preparation and service of food; routine dietary counseling of inpatients; nutritional education; dietetic treatment; and operation and maintenance of a food production service including kitchen, dining room, cafeteria, sanitation, and quality control.
COSTS: Dietetics includes all operating expenses incurred in operating and maintaining the function by contract, except the cost of subsistence. Exclude the expense of nursing service personnel who assist in the serving of food to patients. At those medical facilities where food service to patients is provided by an installation-operated food service facility, the expenses for such services provided at the medical facility are included in the assignment process and will include the expenses for the food and its preparation as identified by the installation accounting system. In this case, all assigned expenses are assigned to Inpatient accounts.
Exception: The expenses incurred to conduct a Nutrition Clinic shall be assigned to that clinic.
PERFORMANCE FACTOR: Rations served.
ASSIGNMENT PROCEDURE: The aggregate expenses to be assigned to direct patient care shall be based on the ratio of patient rations served to the total rations served in the medical facility. Patient rations are those served to patients, excluding transient patients, whether in the nursing units or in the hospital dining room. The assignment of the patient ration portion of the aggregate expenses to the receiving Inpatient accounts shall be based on the ratio of rations served to each inpatient receiving account to the total rations served to all inpatient receiving accounts in the medical facility. The remaining aggregate expenses shall be assigned to the Nonpatient Food Operations and Aeromedical Staging Facilities/Transient Patient Care accounts in the Special Programs section. The assignment to Aeromedical Staging Facilities/Transient Patient Care shall be based on the ratio of rations served to transient patients to the total rations served in the medical facility. All remaining expenses shall be assigned to the Nonpatient Food Operations account.

10. Inpatient Affairs EJ

FUNCTION: Inpatient Affairs reviews clinical records for completeness and accuracy, exercises administrative control of patients and beds, and ensures adequate clinical records are prepared and maintained. Maintains patient control file, patient suspense files, and bed status availability work sheet; prepares biometric reports; prepares correspondence to physicians, lawyers, hospitals, insurance companies, civilian health agencies, and public safety departments; prepares birth and death certificates; and furnishes birth and death lists to the Vital Statistics Office and news media. Prepares requests for medical and physical evaluation boards; acts as recorder and coordinates administrative matters for medical board; counsels patients on information pertaining to medical boards; and initiates and prepares medical findings on line of duty requests. Prepares the Seriously Ill and Very Seriously Ill Lists, prepares documentation required for the Admission and Disposition Sheet; maintains patients' clothing and baggage; advises appropriate organizations of patients admitted from duty, leave, liberty, pass, PCS, or AWOL; initiates third party liability actions; ensures proper clearance of out-going patients; and performs duties associated with clearance of deceased patients. Receives telephone calls and visitors, provides inpatient information, and maintains patient locator file. Reviews clinical records for completeness and conformity with military directives, and standards of recognized accrediting agencies, and places completed clinical records in permanent folders; provides administrative support for patient care audit and utilization review functions; prepares a checklist for missing elements and/or incomplete records, refers to responsible physician or ward for correction; types and processes Clinical Record Cover Sheet and maintains clinical records files and cross reference cards; locates and files previous admission records in current folder for patients readmitted; maintains permanent indexes on patients; ensures adequate security of patient record data and files; retires records and files in accordance with current directives; and maintains a death ledger. Withdraws records from files for physicians, research studies, and committees; prepares data for monthly committee meetings; and prepares research study lists and compiles statistical data. Provides administrative support necessary for the movement of patients from one medical treatment facility to another. Operates dictating machines, transcribes medical data from dictated recordings and drafts, and types medical forms for inclusion in medical records; transcribes medical board summaries, maintains control system of documents received and completed; transcribes documents for

members of the medical staff; and proofreads typed forms and documents. For USA Medical Holding Company/USN Medical Holding Company/USAF Patient Squadron Section functions, see Military Patient Personnel Administration account in Special Programs section. See Decedent Affairs account in Special Programs section.

COSTS: Inpatient Affairs shall be charged with all operating expenses incurred in operating and maintaining the function. The aggregate of these expenses shall be assigned through a stepdown process to the final operating expense accounts. All expenses of military personnel assigned as patients to the USA Medical Holding Company/USN Medical Holding Company/USAF Squadron Section; all expenses of military and civilian personnel assigned to staff authorizations and other expenses to operate and maintain the USA Medical Holding Company/USN Medical Holding Company/Patient Squadron Section, Medical Evaluation Board/Physical Evaluation Board Liaison, and Decedent Affairs Branch; and all expenses of travel and related material costs (for example, litters and blankets) of inpatients, outpatients, and attendants shall be identified, accumulated, and transferred to Special Programs accounts. Any portion of stenographic personnel expenses attributable on a time spent basis to Ambulatory, Dental, and Special Programs accounts shall be assigned to such accounts.

PERFORMANCE FACTOR: Occupied bed days.

ASSIGNMENT PROCEDURE: All expenses, except as noted above, shall be assigned to Inpatient accounts based on a ratio of occupied bed days of each inpatient account to the total number of occupied bed days in the medical facility.

11. Ambulatory Care Administration EK

FUNCTION: Ambulatory Care Administration develops and implements administrative procedures used throughout the ambulatory care function; performs a variety of clerical duties pertaining to outpatients and outpatients' records; conducts technical review of requests for procurement of equipment for components of the ambulatory care function; and administers the health benefits information program. Provides centralized appointment services; records demographic and appointment data; provides cancellation and rescheduling service; notifies record maintenance section and clinics of appointments and changes; provides information to callers not desiring appointments. Provides for reception of ambulatory patients and their referral to the various clinical services; determines eligibility for care and treatment of all categories of outpatients; maintains administrative control over active duty consultations referred to the facility and processes consultation requests; establishes a new terminal digit outpatient treatment record on patients who have not previously received outpatient care; prepares outpatient recording cards as required, and maintains the locator media for outpatient records. Counsels and advises patients seeking information on health benefits as related to the CHAMPUS program; prepares non-availability statements as directed; and collects, collates, and reports statistical information on health benefits as required. Maintains the terminal digit filing system for outpatient treatment records; files dictated outpatient treatment notes, special request forms (laboratory, x ray, etc.) and related materials in the proper record jacket; reviews outpatient treatment records to ensure completeness and conformity with military directives and standards of recognized accrediting agencies; ensures the daily issue of records from the centralized file, including retrieval of records and forwarding them to clinics in advance of scheduled appointments; and receives, transfers, and retires all outpatient records and prepares duplicate copies of outpatient treatment records, as required. Transcribes outpatient treatment notes, physical examinations, consultation reports, etc., dictated by clinic medical officers, and forwards record entries for signature and inclusion in the patient's record.

COSTS: Ambulatory Care Administration shall be charged with all operating expenses incurred in operating and maintaining the function. The aggregate of the expenses shall be assigned through a stepdown process to Ambulatory and Special Programs accounts.

PERFORMANCE FACTOR: Outpatient visits.

ASSIGNMENT PROCEDURE: The aggregate expenses charged to Ambulatory Care Administration shall be assigned based on the ratio of outpatient visits to each receiving clinic account supported for record maintenance to the total outpatient visits of those clinics.

APPENDIX B

Quarterly Partnership Cost Analysis - BAMC

October - December 1990

Inpatient Services	* CHAMPUS	PARTNERSHIP
Admissions	1173	22
Total Gov't Cost	15,149,924	21,300
Avg Gov't Cost Visit	18,341	968

Inpatient Services Analysis

Partnership cost per admission

968 Avg billed CHAMPUS
+2,280 MEPRS Cost/Case
$3,248

CHAMPUS Cost Per Admission

$18,341 CHAMPUS
- 3,248 Partnership
15,093 Government savings per admission

22 X 15,093 = $332,046 savings

*Based on 12 months data July 89 - June 90

Outpatient Services	CHAMPUS	Partnership
User Beneficiaries	19,722	
Visits	79,656	6,446
Non Visit Services	36,269	
Total Gov't Cost	$5,529,155	$325,907
Avg Gov't Cost Visit	$69.41	$50.55

Outpatient Services Analysis

Partnership cost per visit $78.21
50.55 CHAMPUS
+27.66 MEPRS marginal cost
$78.21

69.41 CHAMPUS
-78.21 Partnership
(8.80) Loss

8.80 dollars is the average government loss per visit as compared to CHAMPUS cost.

8.80 X 6466 = $56,724.80 total government loss for last quarter as compared to CHAMPUS cost.

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